HEALTH INSURANCE FOR THE ELDERLY

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

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HOUSE OF REPRESENTATIVES

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HEALTH INSURANCE FOR THE ELDERLY

WEDNESDAY, APRIL 26, 1989

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:30 a.m., in room 2123, Rayburn House Office Building, Hon. John D. Dingell (chairman) presiding.

Mr. DINGELL. The subcommittee will come to order. The health insurance system of America is sick, and the problems that are associated with Medigap are a symptom of the illness. Private health insurance has left 37 million Americans uncovered. It also falls short in the much easier job of filling the gaps of some 33 million Americans dependent on Medicare.

The problems about which we will hear today are uniquely those of every American. They do not occur in other Western nations. We spend our energies assuring that every citizen receives high quality care at a price that society can afford. While we strive toward that goal, there is much that is not done and much more that we can do. The first step is to recognize that a serious problem exists.

Today, witnesses will graphically illustrate systemic problems in the way health insurance for the elderly is sold and regulated. The problems are not confined to one part of the country or to one State. Wherever the subcommittee has looked, it has found significant problems.

Agents sell insurance on the basis of fear and oversell. Companies actively market and sell low value policies. Regulators at the level of the Federal and State governments have allowed these abuses to continue.

The subcommittee has had called to its attention an 82-year-old man in Florida, who told our staff that an agent had scared him and confused him, and ultimately sold him more than $4,000 in unneeded policies. His annual income was $10,000. He was embarrassed, and assumed that he was the only one who had been taken.

A woman described how an agent had virtually coerced her infirm 82-year-old mother-in-law to sign checks to buy unneeded policies.

In Massachusetts, a State which has rigorous enforcement and relatively well priced products, out of State sellers apparently use deceptive advertisements to induce people to buy their products.

In Wisconsin, agents posing at government officials have tried to sell health insurance to the elderly.

In Washington and Illinois and around the country, clever marketers bent on deceit have mailed advertisements meant to look like they are from the U.S. Government or from senior citizen organizations.

Today, the committee will hear about disturbing cases of abuse in Texas, California, Missouri, and here, in the District of Columbia. In some cases, old people paid tens of thousands of dollars for insurance that should have cost only a few hundred dollars.

The Medigap market is small, relative to the staggering national health bill. But it is singularly important and it is peopled by persons of low resistance, limited ability to defend themselves, and considerable difficulty in understanding complex insurance problems.

First, it is to be noted that some $10 to $15 billion annually is not small potatoes to the elderly, many of whom live at, near or possibly below the poverty line. Ten to $15 billion spent well would and should buy a lot of needed services.

Second, our effectiveness in regulating Medigap tells us much about the proper balance between Federal and State regulation. Having found enormous abuses in the 1970's, the Federal Government stepped in and delegated again primary responsibility to the States. The record of the States is mixed. The evaluation of the system that we now have and what it suggests for regulation of other critical areas, such as long term care continues.

Third, everything that has gone wrong in the sale and regulation of Medigap insurance is occurring with long term care insurance. The hard fact is that if we cannot adequately regulate Medigap insurance, we will simply have to try a different approach when it comes to long term care. The potential for abuse and for profiteering there is enormous.

Elderly citizens deserve special protection. When their kindness, trust and openness are rewarded with deception, theft and low value policies, cynicism has to result.

I would note that the health insurance industry has been offered an opportunity to testify. Regrettably, they chose instead to submit written testimony for the record. While the subcommittee does not usually include unsworn testimony in the record the Chair will, by unanimous consent at the appropriate time, insert the industry's statement into the record as a part of these proceedings.

When companies sell poor quality products at high prices or make ridiculously high profits at the expense of persons of limited ability to pay or respond to the challenge of the sale, the companies should be called to account. When con men and artful ad men use the mails to deceive people, they have to be called to account and compelled to shut down.

There will always be shammers and schemers. The Nation has to see to it that their job is not easy. Taking advantage of old people is easy, too easy. It is also reprehensible, and it is the view of this subcommittee that it must stop.

The Chair recognizes the gentleman from North Carolina for an opening statement.

Mr. McMillan. Thank you, Mr. Chairman. I appreciate the fact that this subcommittee is continuing its investigations into the sale

and regulation of so-called Medigap or Medicare supplemental health insurance policies to our Nation's senior citizens.

I think it is an important area for us to explore, particularly in the light of the ever increasing numbers of our citizens who are now eligible for such policies and who, because of their Federal budget realities and uncertainties about recently adopted catastrophic coverage under Medicare may continue to require more for their own health insurance needs.

They certainly need to be afforded the full opportunity to know exactly what they are purchasing when they buy one of the these policies. I hope that these investigations will focus the attention of Congress on the broader issue of health care and health insurance for all citizens.

We desperately need to come up with a coherent, comprehensive reform package that will address the whole issue of health care, not only for our seniors but may also explore ways to encourage and stimulate expanded private sector coverage for some 30 percent of our population that now carry no insurance. I hope that these hearings will lead us in that direction as we proceed.

Mr. DINGELL. The Chair thanks the gentleman. The gentleman from Oregon, Mr. Wyden.

Mr. WYDEN. Thank you very much, Mr. Chairman. I want to commend you for undertaking what I think is a very important inquiry, and particularly all the personal time that you put into this issue. I also want to commend the staff, because they have pursued this matter for quite some time and I think they have done an excellent job.

Mr. Chairman, while there are many responsible insurance companies and agents in this country, the unfortunate fact is there still are a substantial number of ripoff artists who are employing sleazy practices designed to try to dupe the elderly. It is my view that these hucksters shouldn't even be allowed to call their products Medigap policies. They ought to be forced to call them Medigap policies, because they really are a gyp and worth little more than the paper they are written on.

I think it is particularly important that you undertake this inquiry, Mr. Chairman, given the history of the Medicare program. That is, every time that there is a major change in Medicare, such as they has been with the catastrophic health legislation that has been enacted, every time that there has been a major change the hucksters move in and try to take advantage of the confusion that occurs during any transition period.

I have received documents that indicate right now, some of these hucksters are trying to exploit citizens in my State. For example, just in the last month, we have had problems in our State with something called the Medicare claim look alike. It comes from a company, seniors get an official looking envelope with an insert that is very similar to a Medicare claim.

The look alike States that Medicare has denied payment for a service, and if the senior citizen has any questions he should call the always ready to help insurance company listed on the form. Right up at the top—and maybe I will pass this to our colleagues—the number of the company is listed.

I called a senior citizen in Oregon yesterday and my staff spoke with the senior, who didn't remember any claims with Medicare payment and was very confused about this, but was uncertain about whether they ought to call this company to try to get corrected some problem with the payments.

The Oregon Insurance Commissioner is looking into this right now. This is something that has happened in my State just in the last month, as an example in my view, of some who are certainly trying to take advantage during this confusing period after the catastrophic care legislation has been enacted.

The other thing that concerns me, Mr. Chairman, is the growing development of what is known as cold lead marketing. With this kind of approach, people over age 65 are sent mailings that say cutbacks are being made in Medicare and more information is offered to those who return enclosed prestamped postcard. The companies then send out the mailings. They are not, themselves insurance companies. However, the names of those requesting information are sold to insurance companies that market the Medigap policies.

Virtually all the State Insurance Commissioner Offices, the NAIC and senior citizen groups that were contacted by the FTC believe that cold lead marketing is deceptive and misleading. But still, it's going on in this country and it's clear this is an area where this committee in conjunction with the States and industry have got to do more to protect against ripoffs.

The third thing that concerns me, Mr. Chairman, is that incredible as it seems is that companies and agents are trying to sell policies that make seniors more out of pocket than one could possibly obtain in coverage. I have another example of one of these policies as well. It offers two choices; Medigap plan that pays the Medicare Part B deductible of $75, and a Medigap plan that doesn't pay the Medicare Part B deductible of $75.

If the senior chooses the plan that covers the Medicare Part B deductible under this policy, the senior would pay the company $99 more for $75 worth of coverage. This is something that is out there at this point, that has been collected in our inquiry, as an example of the kind of ripoff that is taking place with seniors in our country.

I talked to the Oregon Insurance Commissioner Complaints Division yesterday. They told us that there are still problems with seniors buying multiple and duplicative policies, mass confusion about policies is still a serious problems, instances of people buying close to 30 policies in my State. A particular case that the Insurance Commissioner is following up on is where a senior spent her entire monthly income on health insurance policies.

I think Mr. Chairman, while it is very clear that the private sector should play a significant role in meeting the health care needs of our citizens, we are going to have to take additional steps after the Baucus Amendments have been in place, to protect the rights of older people in this country and do it now, given some of the additional problems that have stemmed from the catastrophic health care legislation and the fact that more long term care insurance is marketed as well.

I look forward to our inquiry, Mr. Chairman, and to working with you.

Mr. DINGELL. The Chair thanks the gentleman from Oregon. The Chair announces our first panel is Mr. Don Gartner, Esquire, Assistant District Attorney, County of Santa Cruz; Emery Walton, Esquire, Criminal District Attorney for Eastland County, Texas; Ms. Bonnie Burns, Elderly Advocate from Scotts Valley, California; Gerhardt Lehmkuhl, Esquire, Attorney, St. Louis, Missouri.

We welcome you, and we are delighted that you are with us.

The Chair has a couple of announcements before we commence. First, we apologize to you that a quorum call delayed the business of the committee. We regret that we have inconvenienced you in that regard.

Second, the practice of the committee is that all witnesses testify under oath. Ladies and gentlemen, do any of you object to appearing under oath this morning?

[No response.]

Mr. DINGELL. You are, in view of that entitled, however, if you desire to be advised by counsel during your appearance here. Do any of you desire to be advised by counsel during the time you appear before the committee?

[No response.]

Mr. DINGELL. Very well. For your information, to inform you of the rules of the committee and the rights that you have as you appear here before the committee and limitations on the part of the committee, copies of the rules are there before you in the red and green books. They show the rules of the House, the committee, and the subcommittee relative to your appearance here today.

Ladies and gentlemen, if you will then please rise and raise your right hands, I will swear you.

[Witnesses sworn.]

Mr. DINGELL. You may each consider yourself, therefore, under oath. The Chair will recognize briefly the distinguished gentleman from Virginia, Mr. Bliley, the senior Minority Member, for purposes of an opening statement and then we will proceed to recognize each of you in appropriate order for your statements.

Mr. BLILEY. Thank you, Mr. Chairman. Certainly every elderly consumer deserves the right to make an informed, rational choice when deciding to purchase a Medigap policy. No one condones high pressure, abusive sales tactics in the marketing of Medigap policies.

When agent misconduct is shown to have occurred, most State commissioner's can revoke or suspend an agent's license. If acts of fraud and misrepresentation are involved, the offending agent should be prosecuted to the full extent of the law.

This is not a new issue. Congress has examined it many times over the past decade. In 1980, public response to reports of misleading sales practices and restrictive benefits led to Congressional enactment of the Baucus Amendment in 1980. This law defines minimum standards for health insurance policies that can be marketed as Medigap policies.

Since the passage of the Baucus Amendment, there have been several efforts to evaluate the effectiveness of the law, and in improving the marketplace for Medigap policies. These reports have shown that widespread consumer abuse have diminished substantially, in that most elderly Americans are being protected against substandard Medigap policies.

For example, in 1986, the Government Accounting Office issued a report on the effectiveness of the Baucus Amendment. The report concluded that the Baucus Amendment, when combined with State efforts, appears to be meeting the objectives of protecting the elderly against substandard Medigap policies and providing them with information on how to select those policies.

In 1987 the Health Care Financing Administration, HCFA, reported to Congress that while some indefinable problems continue, the States have dealt adequately with many of the past problems. The study also concluded that for States that had adopted the Baucus Standards, there was no need for a federally mandated program for Medigap policies as opposed to the voluntary standards under the Baucus Amendment.

September, 1988, the Federal Trade Commission conducted a consumer study of Medigap policyholders that found that 94 percent said that their insurance company paid them what they expected to receive. Moreover, 97 percent said they were satisfied with the company's performance on the claim that they submitted.

Mr. Chairman, I think the general impression that can be drawn from these studies is that many of the problems identified with marketing the Medigap policies have decreased, although they have not disappeared. Clearly, since the 1980 reforms, problems have diminished through the monitoring of sales practices by State insurance departments, insurance companies and agent professional associations.

In this regard I feel that, in particular, this hearing could be more productive if representatives from the agent community were here to voice their ideas. Clearly, their input is crucial when we address this issue in the future.

Thank you, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman. The order of appearance of our witnesses will be Mr. Gartner, Ms. Burns, Mr. Walton and Mr. Lehmkuhl. The Chair recognizes you, Mr. Gartner, for your opening statement and we thank you for being with us.

TESTIMONY OF DON GARTNER, ASSISTANT DISTRICT ATTORNEY, COUNTY OF SANTA CRUZ, CA; BONNIE BURNS, MEDICARE SPECIALIST, SCOTTS VALLEY, CA; EMERY C. WALTON, CRIMINAL DISTRICT ATTORNEY FOR EASTLAND COUNTY, TX; AND GERHARDT B. LEHMKUHL, ATTORNEY, ST. LOUIS, MO

Mr. GARTNER. Thank you, Mr. Chairman. I am an Assistant District Attorney for Santa Cruz County, California. My office is litigating two civil lawsuits involving insurance and the elderly, which seeks substantial monetary penalties, restitution——

Mr. DINGELL. Mr. Gartner, you are going to find that this committee room has probably the worst public address system that you will find anywhere in the United States. You have to pull that microphone to you or nobody is going to know what you are saying, and we all want to hear it.

Mr. GARTNER. Let me start again. I am an Assistant District Attorney for Santa Cruz, California. Our office is litigating two civil lawsuits dealing with insurance abuse and the elderly, which seeks substantial monetary penalties, restitution and injunctive relief.

In the first case, *people of the State of California* v. *Bedrossian Insurance Agency,* et al., we have hundreds of elderly people who have purchased unnecessary insurance from the same agency, often from the same subagent.

The case began upon receiving a letter from a widow, now 83 years old, who purchased 12 insurance policies in 3 years from the agency as well as other policies through the mail. Her son complained after reviewing his mother's check statements while preparing her 1985 Income Tax returns, discovering that she had paid over $6,000 in premiums in 1985. During parts of 1985, this woman had five simultaneous insurance policies that were either Medicare supplements or were related to Medicare supplements.

In the committee room there are charts showing the insurance histories of representative victims. Unfortunately, a number of the charts were cut in half and are not here in total, and only a portion of these histories are depicted. I believe the committee will get the idea.

For example, Ruth C.—I am attempting not to use their last names—an 87-year-old, purchased 14 policies between September of 1985 and May of 1987 from the same agent and paid over $10,000 in new policy premiums during this time. She was interviewed by representatives of the District Attorney office in the summer of 1987.

She lived alone, and it was obvious at that time that she was in the beginning stages of Alzheimer's Disease. In fact, that fall, a few months later, she was conserved by the public guardian of Santa Clara County with a diagnosis of Alzheimer's disease.

Nellie H. is an 82-year-old woman living alone. Her chart is one of the ones that has been cut in half. It is depicted on the right on the wall there. She has been incapacitated since the 1930's from injuries sustained in a fall. She takes medication for chronic pain, and gets around her house only with the aid of a walker. She is essentially homebound.

The chart shows that she purchased 20 policies from this agency, 19 in approximately 2½ years. Of the 19, she had the wherewithal to turn three down and 16 were actually issued.

Elizabeth P., 79-years-old, purchased 24 policies including seven Medicare supplements in less than 6 years. Georgia D., another 87-year-old, purchased 19 policies in 3½ years. Grace and John K. who are not depicted on the flow charts here but are listed in a separate computer printout we provided to staff, purchased five policies on February 24, 1985, and four more 3 weeks later on March 18, all from the same agent.

On February 24, the agent showed up at their door before dark and stayed until 11 p.m., when the agent finally got signatures and checks. The only income of this couple who were childless, was $838 per month in social security.

Agents sell duplicate policies and enroll people into new policies annually in order to generate the very high first year commission, typically 60 to 65 percent upon sale of a new policy instead of the low 5 to 15 percent commission received upon renewal of an old policy.

The elderly lose economically from this rolling or twisting by buying unnecessary insurance. They pay double premiums when

rolled or twisted into similar coverage with new companies. Twisting is the insurance term of art or the insurance analog for churning in the securities field. It means moving people for unnecessary reasons for the purpose of generating commission.

New coverage doesn't pay for a period of months for health conditions which exist when taken out, so when agents twist people from one policy to another for purposes of generating commission, the two policies are overlapped for a period of time in order to take care of the waiting period. And, during this overlapping period, the insured pays unnecessarily twice.

The financial incentive to twist the elderly into unnecessary insurance is shown by a separate chart that represents an essentially identical transaction repeated with 360 of our victims. In each case, a person was moved from a Medicare supplement policy of the United American Insurance Company to an equivalent but higher priced supplement of the American Integrity Insurance Company for the purpose of generating new, high first year commission for the agency and the agent.

You get the idea through the comparison. Instead of $333 for the selling agent upon sale of a new policy, the agent would have received $47 had the agent renewed the old policy, which would have been appropriate. In the agency's case, the agency received $500 upon twisting and would have only received $123 upon renewal or upon upgrading.

The engine which drives elderly insurance abuse is the differential commission structure, the high first year and low renewal commissions. Until the commission structure is substantially leveled out, this abuse is going to continue. This abuse is not confined to Medigap insurance. It also extends to related health insurance, hospital indemnity insurance, medical/surgical insurance, long term care insurance.

Until the differential commission structure is leveled out, this abuse is going to continue. A strong law defining and limiting multiple sales of Medicare supplement and again related insurance policies, is also plainly needed. The Baucus Amendment tried, but it didn't succeed for reasons that I will go into later.

Standardization of policies is also important. California has about 200 Medicare supplements approved for sale with myriad ways of covering in dense language the same item. With such variation, there is little competition on price or quality of product. A consumer, old or young, cannot set two Medicare supplement policies side by side and make an informed choice as to which is better or cheaper.

Neither, for that matter, can a D.A. or a Department of Insurance Regulator readily determine that a policy duplicates an earlier one in order to decide whether to prosecute for twisting.

Let me briefly talk about a second case in Santa Cruz, where we sued an insurance company instead of a statewide insurance agency named Standard Life and Accident and a general insurance agent it was closely related with, for pushing burial insurance unfairly by means of high pressure tactics and by combining this type of insurance with Medicare supplement insurance in a deceptive manner.

Burial insurance is simply life insurance with low face value sold to the elderly. The agent sent hundreds of thousands of letters soliciting inquiries from the elderly under the name of a phony organization he set up called California Association of Concerned Senior Citizens.

Those who responded received from Standard Life's general agent and from his subagents, the A,B,C approach to selling Medicare supplement and burial insurance. Part A and B of the sales pitch refer to the coverage and Standard Life's Medicare supplement. Part C, which made the offering according to the salesman and according to the insurance agents, better than other supplements for Standard Life's Burial Plan described as $1,000 in final expense coverage.

No mention was made that the two separate insurance policies were being sold. When the policy forms were delivered, the burial plan was combined with a Medicare supplement plan to make them look like a single policy.

Standard Life sold a decent Medicare supplement plan, but it announced over and over again that the key to profitability was burial insurance. The company had a quota for burial insurance, and threatened agents with termination. It had a manual called Standard Life's Golden Age Marketing Guide to Success.

In a section titled Rebuffing Closing Objections, the manual states: "stall your prospect if possible. Chances are good that by putting him off, he will forget his objection anyway." Consider that this advice to stall the client is not directed at 30 or 40 year olds, but rather at 70 and 80 year olds. This is advice directly from an insurance company.

In a section on closes, the manual instructs that good closes are persistent. They know why they are there, and are determined to stay until the prospect knows why he came. Consider a moment the case of the couple that we mentioned earlier, who described how the agent showed up at 5:00 and didn't leave until 11:00 in the evening, at which point they had purchased five policies.

Standard Life's Golden Age Marketing Guide to Success has examples of successful closes. One is called the boiled frog, and I will read it to the committee:

> Mr. JONES. Science tells us that we can take a frog, put him in a pan of water on the stove, and then turn on the heat. That water gets warmer and warmer by the minute but the frog, refusing to face facts thinking it is happening to some other frog, not to him, will sit in that water and literally boil to death.
>
> However, if somebody would come along and thump the pot he would jump out and be saved. Now, Mr. Jones, I am not turning the heat on you, life is doing that. All I am trying to do is thump the pot.
>
> Do you think $1,000 is enough, or should we make it $2,000?

Thank you for inviting me.

Mr. DINGELL. Mr. Gartner, the committee thanks you for your very helpful testimony. Ms. Burns, we will recognize you now.

TESTIMONY OF BONNIE BURNS

Ms. BURNS. Thank you, Mr. Chairman and members of the committee. I have 15 years experience in Medicare claims assistance and insurance counseling in California. During those years, I have counseled or spoken to more than 10,000 seniors. During that same

period, I have seen seniors subjected to the most egregious sales abuses most of us could imagine.

The displays that you see around the room are only a dramatic reflection of a few of the abuses that have come to light. Companies use Medicare changes to sell new and better coverage. In our State and others, companies use the complexities and costs associated with the Medicare program to distort the potential need for insurance. They will use any change in Medicare deductibles to hype the value of more or different coverage.

Companies fuel the sales abuses and escape penalties. Companies pay extremely high first year commissions of 60 percent or more, and then they escape most legal and regulatory actions by disassociating themselves from the sales abuses of independent agents who compete for these lucrative commissions.

A March 1987 study by the Health Insurance Association of America, found that 75 percent of seniors had one Medicare supplement; 14 percent had two; 4 percent had three; and, more than 1 million people did not know how many they had. High first year commissions encourage replacement of coverage, not maintaining coverage in place.

Noting the success of this practice, companies that sell long term care insurance now offer the same high first year commission incentives with many of the same results. Seniors are subjected to deceptive advertising practices. Insurance companies and other entities engage in deceptive advertising practices to seniors, using phony association names that mimic those of legitimate consumer organizations and which are mailed from Washington, D. C. addresses, complete with an official governmental look.

I brought for you today, a few of those that I called from my file which are available here. These are no longer allowed to be mailed into the State of California, but because I do a lot of work with national organizations and people in other States, I hear from them frequently about these very same mailers being available in their States.

The Baucus Amendment is inadequate. The Baucus Amendment even in its updated NAIC version, is inadequate to control the abuses that companies, agents and advertisers can inflict on the public. States have been unwilling or unable to control most of these abuses.

Where State action has been effective against one of these practices, others have poured over the dam of regulatory control. Some agents prey on the elderly. The economic rape illustrated by these timeliness represents a tiny fraction of seniors who have suffered from these abuses. Many of these people are the frailest and the most vulnerable of the senior population, who blame themselves to succumbing to high pressure, fear producing sales presentations.

They didn't buy these policies because they wanted to be overinsured. They were frightened of the potential for impoverishment, loss of independence, and the very real possibility of being a burden on their children. They trusted someone they thought had both the knowledge and the will to help them protect themselves and their families.

Medicare supplement insurance is impossible to understand. Why is it that we are surprised when seniors don't understand

their insurance benefits? How many of us have read and understood our own insurance coverage and could compare those benefits with benefits offered by any other plan?

Let me quote just one of the many ways that a company can pay a Medicare supplement benefit. "We will pay the 20 percent coinsurance and 80 percent of the difference between your charges and the Medicare approved amount, up to 14 percent of the Medicare approved amount after a $200 deductible. There are several hundred different supplements on the market of every conceivable design and payment structure." It is ridiculous to presume that someone can decipher and understand these insurance products just because they are over 65 and entitled to Medicare.

This is not a new problem. I testified about these problems in 1987 along with Mr. Gartner. I promised to return the next time this issue came up, because I believed that any attempt to control this powerful industry would surely fail. You have only to look at the number of hearings held on these abuses since the late 1970's to understand the futility that we in the advocate community feel.

One of these victims could be someone in your own family. Look closely at these charts. These do not represent a few senile old people who cannot take care of themselves. Many of these people are responsible, dignified, older Americans trying their very best to provide for the unpredictable medical costs which they believe will surely come.

They have done exactly what you in the Congress and we in society have asked them to do. They have tried to provide for their own needs so that the taxpayers would not have to. If they did it unwisely, maybe it's because we have failed to help them do it well.

Thank you for hearing us.

Mr. DINGELL. Thank you very much. The Chair recognizes Mr. Walton. We thank you for being with us today.

TESTIMONY OF EMERY C. WALTON

Mr. WALTON. Thank you, Mr. Chairman, and members of the committee. My name is Emery Walton, and I am the Criminal District Attorney for Eastland County, Texas. This is a small rural community, consisting of slightly less than 20,000 citizens. Much of my subject that I have in my papers has already been covered, so as time is of the essence, I will skip onto things which I believe are more important for your benefit.

Mr. DINGELL. Without objection, Mr. Walton, the entirety of your statement will be inserted in the record. So, we will have that before us. There were also a number of other documents that were referred to by the two prior members of the panel. Those will be inserted in the record at the appropriate point also. You are again recognized, Mr. Walton.

Mr. WALTON. Thank you, Mr. Chairman. The basis for my statement is over 21 years experience as a prosecutor in a rural county where we normally have about 500 criminal cases filed annually.

The first case that I would like to refer to is shown as Case number three in my report. This case involves a salesman from the metropolitan area of Dallas and Fort Worth who, during the period of 1 year and 9 months, sold an elderly couple in their 80's thirteen

health care policies and 12 life insurance policies. During this period of time, he got $41,946.29 while the actual premiums for these various policies came to almost $30,000.

This person was like most of them that I have had experience with in over 21 years. He was very nice, very nice looking, he was neat, friendly, and he even took the elderly couple out to eat on one or two occasions. The couple's children and grandchildren lived out of the county. This salesman might have gotten more out of this elderly couple had a daughter-in-law from West Texas not come by for a surprise visit one day.

An investigation has resulted in an indictment for this person, and the case is presently pending. Therefore, I am reluctant to go into a great deal of detail on it because I am having some prosecutorial problems in the case. But, I do have submitted here in the paper that shows seven different companies——

Mr. DINGELL. Mr. Walton, the committee is well aware of your concerns on this matter. We will certainly respect your wishes and concerns here. You may proceed in the fashion that you have just described.

Mr. WALTON. Set forth in the report, Mr. Chairman and members, is the first company that he sold it to. I have husband and wife who he sold the first insurance policy to. It shows that he collected a premium for 1 year for $1,893 for a medical supplement. It covers March 22, 1985 through March 22, 1986.

Then, 3 months later, he comes back and sells him two more medical supplements; one to the husband and one to the wife, with an entirely different company. This covers an overlapping period there from June of 1985 to June of 1986. It goes on down, and the various types are set forth there. There's a medical supplement, skilled nursing care, hospital indemnity, medical/surgical expense, convalescent care, medical supplement, convalescent care and all the way through. The total policy here is 13 and collected $18,608 just for the medical supplement type of insurance.

This information set forth in the report here shows extensive overlapping, not only of the types of policies that were provided but also, the period. The salesman used the technique on this elderly couple on the various cases that he visited that he would come by to visit with them first, because he learned that the company providing their present coverage had become or was becoming bankrupt. Second, on other occasions he claimed to have been there to renew their policies.

There are two other cases set forth in my paper here. One of them involved a case where we did actually convict a man. It involved a salesman from a large mutual health care company that was fired for questionable activities. When he left his company, he took the details of a number of policy holders such as the names, addresses, and the types of coverage and expiration dates of their policies.

Shortly before the expiration date of a policy of a widow lady in my county, he came to her and explained that he had been with the company which had carried her health insurance before but that he changed over to another company which would give her better coverage for less money. He sold her on the idea, took her

annual premiums, with the consequences being that her old policy lapsed for nonpayment of premium.

Her son from out of town somehow learned that he old policy had expired for nonpayment of premiums. He determined what happened and called a law enforcement officer. An investigation was made and criminal charges were filed. As is typically the case, the salesman from the very beginning after he was apprehended, made the comment to the effect of well, it was all the result of a misunderstanding and he wished to refund the premium to save that fine old lady from having to undergo the stresses of a trial.

I determined that the lady was willing to go through with the trial, that she could probably make a good witness, and suggested to her that the salesman, whether or not he would return the premium would depend on how long he got in jail from the judge or a jury. Subsequently, he refunded the premium, entered a plea to the case and went to jail.

The third case is briefly a couple of salesmen from the metropolitan area who came out to an old farm family, made comments to the effect of about how glad they were to be in the country. During the course of the conversation, I am sure that they had observed the elderly couple had some chickens, made inquiries about how nice it would be to have some country eggs. When the fine old lady went out to get him some eggs, he proceeded to sell a policy to the elderly man who had a very definite hearing and memory problem.

When the lady got back, he then told her that they had made a sale to the old man and she determined that it was all right. Fortunately, they subsequently realized that they may have been had. They called in some of their children who were well educated people. An indictment resulted.

When I started to prepare for trial, I realized that the elderly man's memory posed a difficult if not a fatal problem for trial. I talked to the couple and their children and, after advising them of the problems we had, they agreed to accept the money back. However, that was not the primary issue for them. The primary issue, according to them and specifically one of the children was, that they thought they had been ripped off and something should be done. Because of the elderly man's mental condition, we were forced to accept a refund of the premium and drop the criminal cases.

Let me just say that in prosecution problems, you have the normal problems that you have in any other type of criminal case but you have some additional problems when you are dealing with elderly people. First, you have the inability of the elderly to identify the salesperson who may have defrauded him or her and to recall the misrepresentations made to induce that elderly person to buy health care insurance.

Second, they have the embarrassment of having been so—what they call and refer to themselves as a fool or so stupid and they perceive that the whole world will know about what he or she did if they are made to get up and testify in open court. Thirdly, elderly people are oftentimes very independent, and they consider what they do with their own money as no one else's business.

The elderly person feels that he or she can buy as much insurance as he or she damn well pleases, and they usually make the comment after it's all over, it's my money.

There has been some partial solutions offered by statements by members of the committee and from my fellow speakers here, so I won't add to that. I think perhaps one thing is, and I understand the Texas Legislature has just done it is, a uniformity of health care policies kind of like in the casualty field we have a generally accepted automobile and a homeowner policy which provides normally all the coverage anyone needs. You just decide what particular coverages you want there.

Here, as has been spoken before, we have hundreds of different types of health care insurance and it leads to confusion. Also, I have been lucky to take some preventive efforts to help curb abuse, not only of insurance but other types of fraud in my community and my county, which are set forth in the paper here.

Mr. Chairman, it is my pleasure to be here today. Thank you.

[The prepared statement of Mr. Walton follows:]

STATEMENT OF EMORY C. WALTON

My name is Emory C. Walton and I am the Criminal District Attorney for Eastland County, Texas, which is located in West Central Texas about half-way between Fort Worth, Texas, and Abilene, Texas. It is a rural area consisting of slightly less than 20,000 citizens.

I understand that the subject of concern here relates to Health Care Insurance Sales Abuse to the Elderly. I know that time is of the essence and accordingly this statement is as brief as possible; however, I respectfully ask that my brevity not be considered as the extent of my knowledge of the subject matter.

The basis for this statement is over 21 years experience as a prosecutor in a rural county in which there are normally over 500 criminal cases filed annually in the district court (felonies) and the county court (higher grade misdemeanors). Also, I have some knowledge of the subject matter as a result of a close relationship with a college friend who was a director of training for a regional office of a large and major life and health insurance company.

All of my experiences involving possible fraud or swindling of the elderly by health care insurance salespersons have involved out-of-county, door-to-door salespersons. I have never received a complaint of possible fraud or swindling involving local independent insurance agents and/or local door-to-door salesmen of such insurance. Such local people have been extremely helpful to me in every instance when I asked for technical information concerning any possible insurance matter. Also, within the last couple of years I have had Mr. Jim Busby, an investigator for the Texas Insurance Commission, to aid me whenever needed for technical information or investigative assistance.

When I first became employed as the prosecutor in Eastland County, there had been a number of instances of apparent fraud in insurance sales committed on the citizens of the County. I considered these types of cases as a real challenge because I knew that this type of salesmen could generally sell iceboxes to Eskimos and had no reservations in hedging on the truth if not in fact lying to make a sale.

Whenever asked about the subject matter, I immediately think of three cases with interest:

Case 1: This case involved two insurance salesmen who came to an elderly couple's farm in Eastland County. They were nice looking men, neatly dressed and very friendly. The elderly couple were in their late 70's or early 80's and the old gentleman had a very definite memory problem because of his age. The men talked with the old couple for some time and during the time commented about how nice it was to be out of the big city and visiting with a fine farm family; during the conversation, one of the men commented about country eggs, determined that the couple had some chickens, and inquired about buying some fresh country eggs. When the lady went to get some eggs for him, he proceeded to make a sale with the old gentleman and obtained a check from him for the amount of the annual premium. When the lady returned, the agent informed her that her husband had decided on a policy; she determined that her husband had decided on a policy and had paid for it. The

men left shortly thereafter and, of course, went straight to a place in town to cash the check.

The elderly couple afterwards determined that they may not have gotten just what they wanted or what had been represented to them. An investigation revealed that there was sufficient evidence of fraud to warrant an indictment. When I began preparing for a trial, I realized that the elderly gentleman's memory posed a serious, if not fatal, problem for trial. The defense attorney suggested that the best possible solution for the couple would be for the defendants to refund the premium. I asked the elderly couple and all of their children to come to my office for a conference at which time I went over the case with them, the possible chances and consequences of a trial and the winning or losing of the case, and the possible consequences of going through a trial with two slick-talking insurance salesmen. One of the children very definitely wanted the case tried; some of the children didn't think it was to the best interest of their parents to be subjected to a trial; and finally, a large majority, including the elderly couple, asked me to accept a refund of the premium (and the money was not the primary basis for the decision) and to then drop the criminal case.

Case 2: In this case a salesman for a large mutual health care insurance company was fired for his questionable activities. When he left the company, he took details of a number of policy holders, such as the names and addresses of policy holders and the types of coverages and expiration dates of the subject policies. Shortly before the expiration date of a policy of a widow lady in Eastland County, he came to her home and explained to her that he had been with the company which carried her health insurance but had changed over to another company which could give her better coverage for less money; he sold her on the idea and took her annual premium with the consequential result being that her old policy lapsed for non-payment of premium. When her son, from out of town, learned her old policy had expired for non-payment of premium, he determined what had happened and called a law enforcement officer. An investigation resulted in the filing of a criminal charge and finally the man was apprehended.

The salesman, from the beginning, claimed that the incident was all the result of a misunderstanding and tried to refund the premium to "save the fine old lady from having to undergo the stress of a trial." I determined that the lady was willing to go through with a trial, that she could likely make a good witness. I then suggested that whether or not he returned the premium would probably make a substantial difference in what a judge or jury would give him in jail time; finally, he refunded the premium, entered a plea to the offense and went to jail (rather than prison, since the amount involved made the case a misdemeanor.

Case 3: This case involves a salesman who, during a period of 1 year and 9 months, sold an elderly couple (in their 80's) 13 health care insurance policies and 12 life insurance policies. During the time, he got $41,946.29 from them while the actual premiums for the policies amounted to only $29,998.88. He was very nice looking, neat, friendly, and even took the elderly couple out to eat on one or two occasions; their children and grandchildren all lived out of the county and the salesman might have gotten more out of them had a daughter-in-law not happened by for a surprise visit one day while the salesman was there.

An investigation has resulted in an indictment and the case is presently pending; therefore, I am reluctant to go into the case any further except to say it appears to involve a number of alleged fraud and swindling tactics which can be illustrated by some of the information concerning health care insurance policies:

Company	Insured	Premium	Type	Coverage period
No. 1	Husband and wife	$1,893.63	Medical supplement.	March 22, 1985 to March 22, 1985
No. 2	Wife	808.70	Medical supplement.	June 3, 1985 to June 3, 1986
No. 2	Husband	808.70	Medical supplement.	June 3, 1985 to June 3, 1986
No. 2	Husband	1,335.20	Skilled nursing care.	June 3, 1985 to June 3, 1986
No. 2	Husband and wife	1,335.20	Hospital indemnity.	June 3, 1985 to June 3, 1986
No. 3	Husband and wife	1,420.00	Hospital indemnity.	October 15, 1985 to October 15, 1986

Company	Insured	Premium	Type	Coverage period
No. 4	Husband and wife	1,166.60	Medical surgical expense.	October 15, 1985 to October 15, 1986
No. 5	Wife	1,170.00	Convalescent care.	January 28, 1986 to January 28, 1987
No. 5	Wife	1,690.00	Medical Supplement.	January 28, 1986 to January 28, 1987
No. 5	Husband	1,170.00	Convalescent care.	January 28, 1986 to January 28, 1987
No. 5	Husband	1,690.00	Medical supplement.	january 28, 1986 to January 28, 1987
No. 6	Husband and wife	2,010.00	Mediocal supplement.	December 1, 1986 (apparently 1 year)
No. 7	Husband and wife	2,100.00	Medical supplement.	Payment made December 3, 1986 but no policy located.

The foregoing information indicates extensive overlapping of not only the types of coverage but also the periods of coverage.

The salesperson reportedly informed the elderly couple on different occasions that came by to see them about their policies because (1) he had learned that the company providing their present coverage had become or was going bankrupt; (2) he was there to renew their policies.

How possible victims are obtained: In addition to the method of obtaining prospective customers as set forth in the Case 2, referred to above, such door-to-door salespersons obtain prospective customers by the following methods:

1. Mass bulk mailings to "local addressee", and flyers in newspapers and magazines by which people mail in their names, addresses and oftentimes other personal information to companies which result in follow-up contacts by door-to-door salespersons.

2. Advertisements by television and radio with "800" telephone numbers or company addresses which induces people to reply with door-to-door salespersons following up on such "leaders".

3. Exchanges of prospective customer lists between such door-to-door salespersons.

4. From newspaper articles about elderly people and by making inquiries of new and old customers of the names and addresses of other family members or friends who may need the benefit of the coverages provided by the particular door-to-door salespersons.

Sales Techniques: Often the question is raised as to how elderly citizens could fall for the technique employed to create abuse in health care insurance sales. The answer is simple; no one, old or young, is immune to being swindled, e.g., how many times have people bought magazines and other products, for which they had no more need than a pig has for a side saddle, from supposedly young college students who allegedly are working for a certain goal and only need so many more points to help reach a certain goal, prize, scholarship, etc.

Elderly people are much more susceptible than young people for any such scam, financial abuse or swindle because (1) they are generally more trusting of people with whom they come in contact, (2) they are often lonely and enjoy the attention and apparent affections shown by convincing sales people, (3) they have a psychological fear of finding themselves in a future crisis situation of a possible large medical bill which might result in their not being able to afford needed medical services and/or leaving their children burdened with huge medical debts in the event the elderly person dies, and (4) they may be mentally unable to determine what is in their best interest, financial, physical and/or emotional.

The unscrupulous health care insurance sales people are skillful in having an answer for any question or situation. They normally portray themselves as being very friendly, caring, concerned and helpful to an elderly person with such statements as "you remind me of my grandmother", "how lucky your children are to have a dad like you who is concerned about their future by securing sufficient insurance to prevent the possibility of huge medical bills in event of cancer or catastrophic illness", aren't you glad I am able to help you", "well, it's time to renew your policy (or policies) again", "you know, your neighbor Mrs. Jones is buying this same policy and she thinks it's great", "this is a better company financially", "you will have better and more complete coverage"; and an untold multitude of other similar expressions to induce the elderly person to buy whatever health care or medical policy the particular person is selling.

Prosecution problems: In prosecution of this type of cases, the prosecutor encounters some additional major problems in getting the elderly to cooperate in the trial of the person who has swindled or defrauded such elderly person; (1) The inability of the elderly to identify the salesperson who may have defrauded the elderly person or to recall the misrepresentations made to induce the elderly person to buy the health care insurance; (2) The embarrassment of having been such a "fool" or "so stupid", and such elderly person perceives that the whole world will know about what the person did if he or she is made to appear at a trial to testify; and (3) elderly people are often very independent and consider what they do with their money is no one else's business—the elderly person feels he or she can buy as much insurance as he or she damn well pleases because after all "it's my money".

I use the term partial solutions because there is no 100 percent solution to stopping health care insurance sales abuse of the elderly; to think otherwise is like thinking pre-marital sex can be stopped. Nevertheless, this committee's interest and action regarding the subject matter should be such to send out a loud message that health care insurance sales abuse of the elderly will not be condoned. Among the things which could be considered are the following:

1. Uniformity of Health Care Policies: Today, there are almost as many types of health care insurance policies as Carter has liver pills, e.g.: Cancer insurance, medical insurance, dental insurance, surgical insurance, supplemental health and/or medical insurance convalescence insurance, catastrophic insurance, skilled nursing care; hospital indemnity insurance, and numerous others; consequently the elderly are often misled or confused, and the easy victims of abuse in health insurance sales.

In the casualty insurance field, there are generally accepted automobile and homeowners' policies which provide all of the coverages normally needed and allow the insured to choose the coverages and amounts deemed appropriate.

A similar type of generally accepted health insurance policy could be developed for all types of health care insurance.

2. Review of present laws: A review of the applicable criminal offenses to determine where and how such laws pertaining to the subject matter can be strengthened to serve as a deterrent and to discourage acts by unscrupulous salespersons of health insurance to the elderly.

3. Possible legislation: A national license for health care insurance agents could be mandated. This same general idea is in the making for issuance of commercial drivers licenses to certain truckers by the Department of Transportation. A health care insurance license would help eliminate (a) a salesperson whose license is suspended or prohibited in one State from going to another State and getting a license to sell health care insurance in the other State, (b) prohibit such salespersons who have been convicted of a felony or a crime involving moral turpitude, whether probated or by a final conviction, in any State or Federal court from going from one State to another State to get a license, and (c) requiring all such salespersons (whether or not for commercial, so-called non-profit, mutual, fraternal or religious corporations, enterprises, associations or other entities) to have a national license with strict criminal and civil penalties for any violation of the law applicable thereto and to laws relating to the health insurance business. This licensing procedure could also afford a valuable source of information and statistics to appropriate governmental and law enforcement agencies to aid in, the detection of, and to further curtail the subject abuses.

Whenever I receive information or a complaint of possible fraud, swindle or financial abuse, I call the Sheriff and the senior police officer on duty in each of the five towns in the county; I relate to each of them any available information (number and descriptions of people involved, location of the reported incident, nature of the incident—health care or life insurance sales abuse, or possible swindle or fraud involving pest control or terminate service, home siding, home foundation and roof or other types of home repairs, etc.—description of any vehicles, and apparent method of operations. This procedure has proven to be very effective as a deterrent.

I gratefully appreciate the opportunity to present any information which may be helpful to your inquiry or investigation. If I may be of any further assistance, please let me know.

Mr. DINGELL. The Chair thanks you for your very helpful statement. It is good to meet a tough minded prosecutor that can make himself understood to folks like this. Mr. Lehmkuhl, we welcome you to the committee and recognize you for your statement.

TESTIMONY OF GERHARDT LEHMKUHL

Mr. LEHMKUHL. Mr. Chairman and members of the committee, my name is Gerhardt Lehmkuhl. I am an attorney and practice law in St. Louis, Missouri. My practice is predominantly with elderly and poor clients.

Recently one of my clients, whom I shall refer to as Mrs. Smith, was sold a number of insurance policies. I don't know the total, but it's at least 28 policies. One insurance company which issued 10 of the 28 policies replied to my inquiry that in all likelihood some records of policies enforced for only a brief period now have been purged from our system. So, there may have been more than 28 policies.

The timespan during which these 28 policies were issued was from October 27, 1985 to April 11, 1988. All of the policies were sold by one agent working for one insurance agency. The client to whom these policies were issued is a widow born in 1915, so she was about 70 years old when the first of the 28 policies was issued.

She is retired, but she was a nurse and well aware of the high cost of health care. When her husband died, she sold their home and moved into a senior citizens apartment and placed the proceeds of the sale of the home in her checking account. Mrs. Smith suffers from the disease of alcoholism. In February of 1988, she entered a care unit hospital for a month long course of treatment for her alcoholism.

Six of the policies are for life insurance, and 22 are for health care policies. The categories of coverage vary in nomenclature, but terms used by the companies to describe the policies are as follows: post hospital extended care, Medicare supplement, recuperation, surgical benefits, personal crisis, cancer, hospital benefits, skilled nursing, and home health care expense.

These policies overlap in coverage and, yet, there are gaps in coverage. After Mrs. Smith's hospitalization for treatment for alcoholism, so far as I have been able to determine, none of her hospital bills or doctor bills were covered by this insurance. She had extensive tests, x-rays and so forth, but the only coverage she had was from Medicare.

The reason for this is because many of the policies had lapsed or were not in effect at the time of her treatment. Other policies merely covered cancer, surgery, or blood transfusion or nursing home convalescence.

The amount of money paid as premiums is still indeterminate. Clearly, it is thousands of dollars. One policy had a premium of $90 per month and others were for hundreds of dollars per quarter, half-year or year. I might add that I have determined that minimally the amount is $5,865. There is more though.

To investigate or research a matter like this takes a lot of time and correspondence. Checks and records have been lost. The bank, which was the key to the record of payments, took nearly 3 months to send copies of records despite my written requests and visits in person to the bank offices to ask that the matter be sped up. They wanted a deposit up front of $60 to discover the cost of copies of their records, at $15 per hour. If all of this is not appalling to you, I will have to say that it gets worse, a lot worse.

For five the insurance policies, the agent had Mrs. Smith sign draft authorization cards whereby the premiums were regularly taken out of Mrs. Smith's bank account. There are what could loosely be called or termed irregularities about these draft authorization cards.

Two of them are undated, two are left blank as to the amounts authorized to be drafted, one was signed 2 days before she entered the alcohol treatment program, and the spelling on the signature is corrected above the signature.

The result was, a lot of money was taken directly out of Mrs. Smith's bank account, and I don't think to this day she understands what a draft is or what the notices of the drafts were that she received with her bank statement. There were five policies covered by draft payment plans. Yet, most of her policies lapsed. The earliest draft authorization was on the third policy, issued back in November of 1985. The latest was in February of 1988.

The bank cashed stale-dated checks. Apparently in at least two instances, when the agent sold the policy he had Mrs. Smith make out two checks for the premium. One was cashed and the other was presented for payment over 6 months later for the renewal, and the bank paid on them even though they were dated more than 6 months prior. The bank also cashed checks where the amount entered in the numbers is different from the written out amount; $393.37 versus $300.37. They paid $393.37 on that check.

When I went out and talked to the bank officer, he told me that he thought she was being victimized and that they had taken special steps to protect her. The very first health care insurance policy issued has a rider or an alcoholism amendment saying expenses incurred because of treatment of alcoholism would be covered for a maximum of 30 days.

Mrs. Smith knew that she was an alcoholic, the agent who sold her the policy put alcoholism riders on a number of the policies, and he and the agency had noticed the client was an alcoholic.

I don't have copies of the applications for all of the policies but I believe I have 21 of them, and I have not submitted to a handwriting expert yet but this has been suggested to me. I believe that on at least seven of the applications, the signature is not that of Mrs. Smith.

This appears to be a case of rather extensive abuse of insurance and fraud involving thousands of dollars. The clearest violations and the easiest to prove are violations of Missouri Insurance Regulations, but there is case law that denies a private cause of action for those violations.

I do not believe this case is an isolated or rare occurrence. I had another client in 1985 who was sold 12 or 13 health care insurance policies. I recovered about $5,800 in premiums she paid because the policies were all Medicare supplement policies. They were sold to her by five or six different agents working for different agencies. One of those agents worked for the same agency that sold Mrs. Smith her 27 policies. That client was a woman in her 90's.

These are the facts as briefly as I can state them. There is much more that I know, and much more that I intend to find out. I would just say by way of closing, and by way of challenge that the Government of the United States and the legal profession of this

Nation cannot protect its elderly and infirm from such abuse, we stand indicted in the very highest of all courts.

Thank you, Mr. Chairman.

Mr. DINGELL. The Chair is going to recognize my colleagues under the rules, for 5 minutes each. The Chair recognizes first, the gentleman from Oregon, Mr. Wyden.

Mr. WYDEN. Thank you very much, Mr. Chairman. I want to thank all of our panel for an excellent presentation.

Ms. Burns, let me begin with you, if I might. Fifteen years ago I did what you do; I was an advocate for seniors and ran a legal aid office for the elderly. I think your testimony has been very helpful.

One of the things that I would like to start with though, deals with the current kind of environment. It seems to me what you have said and your colleagues is that despite the Baucus Legislation, despite the fact that there are good companies and good agents out there, and despite the fact that there have been very significant public education efforts, there are still a substantial number of ripoffs taking place today; is that correct?

Ms. BURNS. That is correct. In fact, I would like to read to you the section of the Baucus Amendment that makes this possible. The Baucus Amendment allows for Federal prosecution of duplicate coverage. Then it goes on to define duplicate coverage and it is defined in this manner: for purposes of this paragraph, benefits which are payable to or on behalf of an individual, without regard to other health benefit coverage of such individual, shall not be considered duplicative.

So what the Baucus Amendment is really saying is that you can buy 10 policies, and if all 10 will pay, then that is not duplicate coverage. That is what allows this to happen.

Mr. WYDEN. Mr. Chairman, I think this is a particularly important point. During the debate over the catastrophic care legislation, under your leadership, we were particularly concerned about this anti-duplication issue.

Mr. DINGELL. The gentleman from Oregon and I were both very interested in that legislation.

Mr. WYDEN. I appreciate the Chair's comment. This would seem to me, as the Chair goes forward with the legislation, would be one area where we could really close the gap. It would seem to be particularly important after the catastrophic bill, where we were trying to deal with it, given the fact that additional problems are uncovered. That would be an area under the Chair's leadership that I would really like to work on.

Mr. DINGELL. The Chair agrees with the gentleman, and would be happy to work with the gentleman.

Mr. WYDEN. I thank the Chair. Ms. Burns, I want to move into some other areas. One is, are you starting to see the same kind of ripoffs develop with the newer products like long term care insurance that we have seen with the traditional Medigap supplement?

Ms. BURNS. Yes, I am. Agents, when they go to sell, with go in with a package of policies beginning with a Medicare supplement, including a hospital indemnity, medical/surgical, life insurance, maybe a cancer policy, and a long term care policy. I would like to point out to the committee that if people spend $2,000 a year for a long term care policy and that policy is replaced 6 months later,

that person is effectively not only wasting their premiums for that coverage but may, in fact, be buying a policy that won't even pay for the type of long term care that they need.

This is a continuing problem. The high commissions are just as prevalent in long term care if not more so, because the cost of the policy is much greater.

Mr. WYDEN. Tell us, if you would, a little bit about the post-catastrophic care enactment environment. My sense is, having worked in this field is, any time there is a major change in Medicare, the hucksters go out there and try to exploit it.

Are you finding in this kind of transition period after the catastrophic care bill has been enacted, are you finding new problems and people trying to exploit that legislation?

Ms. BURNS. Yes, they are, and for the very reasons that you pointed out. Any change in the Medicare program generates these new attempts to sell new and better coverage.

Mr. WYDEN. Is it correct that if an older person buys one policy and then buys another or a third or fourth and the like, that there are provisions in one or more of those policies known as subrogation agreements, whereby a policy says that if you buy similar coverage we don't have to pay and, in effect, these policies can cancel themselves out; is that something that you find?

Ms. BURNS. That doesn't tend to happen in Medicare supplements and that's a good part of the problem is, that they will all pay. A person can buy three Medicare supplement insurances and every single one of them will pay. In long term care insurance, you may begin to see some coordination of coverage benefits.

The sorts of insurances that are sold to seniors by in large, all of the variety of insurances will pay irrespective of other coverage. I think what you are talking about commonly occurs in employer group coverages, where they will not pay in addition to other employer group coverage.

Mr. WYDEN. What you are saying is that people are just generally frittering away money when they buy more than one policy, and if they are on a tight income they would be better off spending that money on food or fuel rather than on the second or third policy?

Ms. BURNS. That's right, except I really believe this is the agent who is promoting this and not the senior. It is almost unheard of for seniors to call an agent and say I need more coverage. It is more likely that the agent will show up at the senior's door and say that you need more coverage or this company is going bankrupt, or this is a better product or Medicare has done something that makes your product obsolete.

Mr. WYDEN. What about these very low loss ratios the chairman's survey has uncovered? I think still, again after Baucus and after all the changes, companies that still have very low loss ratios. I am looking at some of this data that shows like 20 cents on the dollar, 30 cents on the dollar.

Are we making any headway in isolating those companies that pay such a low loss ratio? That means that they are keeping 70 cents for profit and overhead. Aren't we getting the word out that these companies are really fleecing seniors?

Ms. BURNS. I think that's a continuing problem. If you look at the testimony from prior hearings, I think you will see that the

same companies who have had loss ratios in the early 1980's for instance, are the same companies who still have low loss ratios today.

Mr. WYDEN. My chairman has his gavel in his hand. I look forward, hopefully, to be able to ask some more questions. Perhaps, I could put some additional questions in the record. Thank you, Mr. Chairman.

Mr. DINGELL. Without objection, so ordered. The gentleman was reading from a document; does he want that in the record too?

Mr. WYDEN. Yes. With the Chair's permission, this is the very good analysis that was done for the committee on the most recent loss ratios. With the Chair's consent, it was the GAO study on loss ratios.

Mr. DINGELL. Without objection, that will also be inserted into the record at the appropriate place.

Mr. WYDEN. Thank you, Mr. Chairman.

[The document referred to follows:]

To: John D. Dingell, Chairman Subcommittee on Oversight and Investigations
From: Committee Staff
Re: GAO Study on Loss Ratios of Selected Hospital Indemnity and Specified Disease Policies
Date: 4/25/89

Attached is information on the percentage of premiums returned to policyholders as benefits (i.e., loss ratios) for selected hospital indemnity and specified disease policies.

For this report, GAO obtained 1987 loss ratios, the latest available, for 62 policies--37 hospital indemnity policies and 25 specified disease policies. The findings show that in 1987, the 37 hospital indemnity policies had an average loss ratio of 52.7 percent. Over 62% of the insurance companies fell below that average. The specified disease policies similarly had a 1987 average loss ratio of 59.4 percent. The enclosure to this memo lists for the 62 companies, the name of the insurer, the policy number, and the 1986 and 1987 earned premiums and loss ratios.

ENCLOSURE

ENCLOSURE

1987 AND 1986 LOSS RATIOS OF SELECTED SPECIFIED DISEASE POLICIES

COMPANY	POLICY NUMBER	1987 EARNED PREMIUM	1987 LOSS RATIO (PERCENT)	1986 EARNED PREMIUM	1986 LOSS RATIO (PERCENT)
AMERICAN FAMILY LIFE	A-12000	$119,098,130	51.7	$ 30,266,643	62.3
AMERICAN FAMILY LIFE	A-6925	49,616,098	59.0	48,758,153	73.2
AMERICAN FAMILY LIFE	A-9520	46,197,199	96.8	53,447,866	58.5
AMERICAN FAMILY LIFE	A-9056	37,367,857	65.7	41,807,996	57.7
COLONIAL LIFE AND ACCIDENT	HB00	10,721,155	44.5	4,760,350	44.7
TRANSPORT LIFE INSUR CO	10625/10627	8,921,972	53.5	10,675,243	54.5
TRANSPORT LIFE INSUR CO	10221/10330	8,107,994	53.5	8,598,081	60.9
CAPITOL AMERICAN LIFE INS CO	VG	7,971,185	60.0	8,898,912	48.4
CAPITOL AMERICAN LIFE INS CO	VE	6,442,379	43.1	7,478,161	43.2
CAPITOL AMERICAN LIFE INS CO	GTC-1-C	5,391,677	29.9	4,074,902	33.8
CAPITOL AMERICAN LIFE INS CO	1250	4,683,361	16.9	1,962,207	10.1
COLONIAL LIFE AND ACCIDENT	0592	4,626,861	63.5	5,870,318	82.6
TRANSPORT LIFE INSUR CO	10781	3,769,743	37.0	254,549	0.2
CAPITOL AMERICAN LIFE INS CO	1200	3,590,664	18.2	1,447,668	9.1
TRANSPORT LIFE INSUR CO	10046/10054/10212	2,579,845	68.6	2,560,306	70.5
COLONIAL LIFE AND ACCIDENT	LB00	1,382,425	40.6	677,930	36.8
COLONIAL LIFE AND ACCIDENT	0610	1,114,827	39.0	1,225,971	19.6
COLONIAL LIFE AND ACCIDENT	NCCAN	1,059,420	69.5	585,276	48.7
COLONIAL LIFE AND ACCIDENT	0797	1,025,720	6.5	1,160,828	15.7
COLONIAL LIFE AND ACCIDENT	0124	920,959	22.4	1,036,130	13.9
COLONIAL LIFE AND ACCIDENT	9509C	544,753	50.9	465,953	62.2
CAPITOL AMERICAN LIFE INS CO	VB	409,950	55.4	490,930	49.1
CAPITOL AMERICAN LIFE INS CO	VH	396,325	69.9	441,024	86.1
COLONIAL LIFE AND ACCIDENT	F78	376,662	52.3	479,994	51.2
CAPITOL AMERICAN LIFE INS CO	VF	85,600	38.1	103,899	43.6
TOTAL		$326,402,761	59.4	$237,529,290	59.5

ENCLOSURE ENCLOSURE

1987 AND 1986 LOSS RATIOS OF SELECTED HOSPITAL INDEMNITY POLICIES

COMPANY	POLICY NUMBER	1987 EARNED PREMIUM	1987 LOSS RATIO (PERCENT)	1986 EARNED PREMIUM	1986 LOSS RATIO (PERCENT)
PHYSICIANS MUTUAL INSUR CO	500	$ 69,173,724	45.1	$ 41,391,146	49.0
PHYSICIANS MUTUAL INSUR CO	370	46,444,276	70.8	55,956,982	75.7
PHYSICIANS MUTUAL INSUR CO	510	37,989,365	80.8	46,334,173	62.4
STATE FARM MUTUAL AUTO INS CO	97024	32,356,928	43.7	30,454,280	42.0
PHYSICIANS MUTUAL INSUR CO	350	15,870,239	58.7	19,127,767	62.1
COLONIAL LIFE AND ACCIDENT	F78	12,137,586	37.7	15,328,326	36.3
NATIONAL HOME LIFE ASSUR CO	NH38178,376,679,978	9,473,553	47.8	12,393,133	58.9
PENNSYLVANIA LIFE INSUR CO	P800	8,755,642	21.4	7,217,840	29.1
NATIONAL HOME LIFE ASSUR CO	NH251072	8,710,766	44.4	11,242,825	49.5
NATIONAL HOME LIFE ASSUR CO	NH10171/669/972	8,205,887	30.1	10,153,663	32.5
BANKERS LIFE AND CASUALTY	GR-74J	4,932,960	31.1	5,401,835	33.0
NATIONAL HOME LIFE ASSUR CO	NH50680	3,962,870	30.2	5,900,207	39.4
PENNSYLVANIA LIFE INSUR CO	351	3,271,654	9.7	3,897,444	17.4
BANKERS LIFE AND CASUALTY	GR-795	2,499,862	101.1	3,240,434	98.4
PHYSICIANS MUTUAL INSUR CO	380	2,409,856	58.6	2,844,697	65.4
PHYSICIANS MUTUAL INSUR CO	360	1,950,744	46.0	2,332,539	50.5
BANKERS LIFE AND CASUALTY	GR-74K	1,876,339	36.2	2,635,509	40.9
COLONIAL LIFE AND ACCIDENT	HCI	1,800,181	40.7	2,318,795	35.2
PENNSYLVANIA LIFE INSUR CO	SDP21	1,750,460	23.1	1,664,712	34.1
BANKERS LIFE AND CASUALTY	GR-74X	1,653,259	28.8	1,365,616	29.1
MUTUAL OF OMAHA	H010	1,351,181	40.0	776,364	22.1
COLONIAL LIFE AND ACCIDENT	HCI-P	1,186,812	39.7	933,868	50.4
MUTUAL OF OMAHA	H02	1,165,423	39.7	477,926	25.7
MUTUAL OF OMAHA	93H0	959,446	37.1	1,292,303	41.8
NATIONAL HOME LIFE ASSUR CO	NH49480	841,559	74.2	1,120,688	77.9
PHYSICIANS MUTUAL INSUR CO	340	603,791	42.4	705,529	58.9
NATIONAL HOME LIFE ASSUR CO	NH80884	598,788	18.9	445,889	23.4
NATIONAL HOME LIFE ASSUR CO	4210	524,980	55.9	633,904	85.4
COLONIAL LIFE AND ACCIDENT	HCI-RE	364,252	39.5	252,353	56.0
PHYSICIANS MUTUAL INSUR CO	186	313,960	38.2	348,170	56.9
MUTUAL OF OMAHA	H010K	226,664	58.4	118,046	22.8
NATIONAL HOME LIFE ASSUR CO	NH94485	196,636	35.3	167,055	44.5
PHYSICIANS MUTUAL INSUR CO	158	139,626	57.1	168,037	62.5
NATIONAL HOME LIFE ASSUR CO	NH85584	139,454	58.7	117,239	67.1
MUTUAL OF OMAHA	H01	132,636	79.8	142,876	38.7
PHYSICIANS MUTUAL INSUR CO	187	87,257	48.5	425,019	41.7
NATIONAL HOME LIFE ASSUR CO	NH55181	64,739	61.9	112,141	45.1
TOTAL		$284,123,355	52.7	$289,439,330	54.6

Mr. DINGELL. The Chair recognizes now, the gentleman from North Carolina, Mr. McMillan.

Mr. MCMILLAN. Thank you, Mr. Chairman. I thank each of you for your testimony here this morning and the deplorable cases that you have presented to us. I think one of the things that we have to try to focus on is to the degree to which these practices may be already in violation of the respective State statutes or ethical practices of the industry, and to what degree they are being prosecuted.

The second would be to determine how widespread they are, which I think has a lot to do with the nature of the remedy that may be proposed.

One of the points that you raised, Ms. Burns, I find somewhat intriguing. It has to do with the fact that you, I think, correctly point out that very few of us understand what kind of insurance coverage we have. That is not a generational issue, would you agree? It is, perhaps, almost universal.

Ms. BURNS. I agree.

Mr. MCMILLAN. Then we get to what is the solution or remedy to that question. It seems that all too often the government's attempts to remedy that situation have not been very successful either. How many people understand what their benefits are under Medicare or catastrophic insurance or Medicaid?

Ms. BURNS. I agree with you that that's a problem, but I would also point out to you that in most States you couldn't buy two auto insurance policies for instance that exceeded the total value of the car for collision coverage, or you couldn't go out and insure a $100,000 house for $1 million.

We allow seniors to buy all sorts of insurance without any cap on the ultimate payout of those policies.

Mr. MCMILLAN. Is that because of an industry practice, or because of State law with respect to say automobile insurance and house insurance?

Ms. BURNS. It's definitely part a State law problem, I think. But I also think that if you look at the kind of health insurance sold to seniors, you will see that it is very different in the way in which it is sold and in the amounts that are allowed to be sold than what you will find sold to younger people.

Mr. MCMILLAN. That could well be and, certainly, it could be a target for exploitive activity. Why do you think the State laws appear to be adequate or more adequate in the case of automobile and household insurance as opposed to Medigap insurance?

Ms. BURNS. I think people recognize the loss potential for property differently than they realized it for health care, and that's part of the problem. I have also been involved with attempts to write and pass bills in the California State Legislature, and the insurance industry is an extremely powerful group of people.

In order to get something through our State Legislature, we either have to have a very big grass movements effort or we have to get the insurance industry somehow on our side, and that usually means a compromise.

Mr. MCMILLAN. You would say that the insurance industry is on our side with respect to household coverage and automotive insurance?

Ms. BURNS. I think that insurers recognize very quickly that they do not want to insure property for more than its value, but they don't seem ready to apply that to the insurance that is sold to older people in the health care area.

They recognize it very quickly in employer group coverage for younger people. They have coordination of benefit clauses in every employer group contract. You can't collect more than 100 percent of your costs for health care if you are under 65, and if you are over 65 you can.

Mr. MCMILLAN. That is probably a result of the corporation exercising responsibility; is it not?

Ms. BURNS. I think it is an affect of the Baucus Amendment, which says that you can't bring a Federal case if both policies pay.

Mr. MCMILLAN. I would think that we would be more concerned about Medigap coverage than we would household insurance. If I have a $100,000 house and I want to pay the premiums and insure it for $200,000 and the premiums are related to the risks, that perhaps should be my personal business if I choose to do that.

Ms. BURNS. I think if you will look at the many studies that have been done about even the need for a Medicare supplement, you will see that the need has been decreasing and the exposure and risk for what companies have to pay is also decreasing.

Mr. MCMILLAN. I am going to make one final comment because my time has expired. I think Mr. Walton mentioned the fact that the Texas Legislature had either adopted or was considering a model policy.

Mr. WALTON. That is my understanding.

Mr. MCMILLAN. Which strikes me as a very positive way to go about dealing with that. It tends to set up standardized types of coverage that dovetails with Medicare, and perhaps, the Federal role would be to offer the right kind of inducement or incentive to make that policy an attractive vehicle that deals with a lot of the issues that you have addressed such as duplicate coverage, excessive premiums, et cetera, but has some real strong incentive in there to make it understood by the public and understood by those who serve the public.

Ms. BURNS. Several States have adopted Medicare standard policies, and we attempted to do that in California. In fact, our Department of Insurance has been asked to develop three standard Medicare supplements that can be sold in the State. That would allow for the side-by-side comparison that is so difficult now.

The other thing that would help would be mandatory assignment. A majority of providers under Part B of Medicare already accept assignment. The few who don't are allowed open access to the pocketbooks of the elderly, and that is primarily the reason that people in California buy Medicare supplements. It is not for the 20 percent co-insurance coverage, it's for the excess charges or the balance billed amount.

Mr. MCMILLAN. Thank you, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman. The gentleman from Pennsylvania, Mr. Walgren.

Mr. WALGREN. Thank you, Mr. Chairman. I guess my curiosity—and not knowing much about the insurance area—runs to where

has the Federal Government been in this? As I understand it, we have left substantial regulation to the States.

Do we have any Federal regulations that would reach the kinds of problems that you have testified to here today?

Ms. BURNS. We have Federal regulations through the Baucus Amendment, which did set minimum benefit standards that policies had to meet, a level floor as it were, in order for a policy to be sold as a Medicare supplement.

But beyond that, the Federal Government has not taken a role in the sale or regulation of these policies.

Mr. WALGREN. In many of these instances where the real abuse comes, it probably doesn't matter whether it's a Medicare supplement or not. If people are induced into being willing to buy something and give a draft authorization to draw it on their bank account because they are flattered by the attention that is given them by a salesman, it almost doesn't—this is something that is almost not a Medicare coverage.

Mr. GARTNER. A key for the Congress is to have its regulations extend beyond simply Medicare supplement insurance to related forms of insurance. If, for example, you respond to Mr. Wyden's suggestion and develop a decent law regulating the number of Medicare supplements a person can buy but do nothing to deal with related policies such as hospital indemnity or medical/surgical policies, you will have one Medicare supplement and three hospital indemnities and two medical/surgical policies.

So, what you need to do is to develop standards that apply to all the forms of health insurance that are sold to the elderly here.

Mr. WALGREN. It would seem that the first step is to have only one policy. If you don't close that possibility, then certainly the abuse could not be stopped for a confused person.

Mr. GARTNER. All the comment here so far has been directed at eliminating multiple sales, having only one policy. If that is all the Congress confines itself to, you will leave the problem of twisting people from one policy to another which, in my view, is the most serious problem right now.

As long as you have 60 percent commission upon sale of a new policy and 5 to 15 percent upon renewal, that difference—there are relatively few agents who will bring attention to themselves by stacking people with three, four or five simultaneous policies. They have little incentive to do that.

Rather, they will simply be moving people from one policy to another year after year after year, every 6 months, in order to generate new first year commissions. It is much more difficult for a prosecutor to look at a case where a person had one policy in January of 1985, a second one in September of 1985, a third one in June of 1986 and so on, and see that as an abuse as opposed to a situation where a person has three or four sold on the same day.

That situation, which we portrayed here, is less usual than the constant twisting people from one insurance policy to another for the purpose of generating new first year commission. That is going to go on as long as you have agents who want to make a 60 percent the first time around, and know that if they simply leave the person in the existing good coverage that they sold the first day, all they will get as 5 percent of the new premium.

Mr. WALGREN. Any suggestions as to how you would stop that?

Mr. GARTNER. Yes. You level out the commissions, and apparently, some States have begun to do that. You pass a law that provides that commissions upon sale of a new policy and commissions upon renewal are the same. Once you do that, the incentive for the agent to twist into new first year coverage with different companies with the inevitable overlapping, the inevitable new sales pitch, the inevitable confusion will be gone.

The agent will have sold an initial good policy and will keep the person in that policy, and the agent will get a level commission each year. There is no reason that can't be done. You will get all sorts of fancy accounting justifications for why expenses are stacked into a first year and why companies therefore have to pay additional sums in the first year, but if you sit the companies down you will find that they don't want to pay 60 percent the first year.

Everybody will be happy. They need the Congress' help here, because no one company can do it alone. If one company were to level out commissions, all the agents would run to the insurance policies of the companies that still pay 60 percent upon a first year sale. If there was a uniform law that provided for example that instead of 60 and 10 you had 35 and 35, you make an enormous difference in this constant twisting and this constant churning.

Mr. WALGREN. My time has expired. Thank you, Mr. Chairman.

Mr. DINGELL. The time of the gentleman has expired. Members of the panel, we are very grateful to you for your very helpful statements and assistance to the committee. You advice, I believe, will be of great value to the committee in terms of our addressing the problem that is now before us.

The Chair would like to direct a few questions to Mr. Walton. Mr. Walton, you seem to be saying that an agent can easily succeed in committing fraud by appearing kind, just as easily as by using fear; is that correct?

Mr. WALTON. Yes, sir.

Mr. DINGELL. Are there differences in the insurance agents you have come up with, with regard to their behavior and some of the other common criminals that you have prosecuted?

Mr. WALTON. Yes, sir. I regard them the same. However, they take a different tactic as opposed to a burglar or robber, or something like that. You take the hardened criminal, what we normally refer to as the hardened criminal, they denote evil from the beginning and that's what you know they are.

Whereas, you take some of the unscrupulous door to door salesmen, they come in and are smooth and polished, they have an answer for every situation, they are kind, considerate, they go about it—somebody in here mentioned fear. The experience that I have had is not actual, physical fear, but psychological fear.

They do this saying something to the effect of, you don't want your children to be burdened with a terrible medical bill if something happens to you. They operate on their psychological scares of leaving their children burdened with a tremendous insurance bill. In my opinion, they are as bad as robber.

Mr. DINGELL. They don't use a gun.

Mr. WALTON. No, sir.

Mr. DINGELL. They use psychology.

Mr. WALTON. Yes, sir.

Mr. DINGELL. Oftentimes, they get a whole lot more than a fellow who used a gun and broke into their home at night.

Mr. WALTON. Mr. Chairman, I have seen a few instances where people were completely liquidated of their financial resources. You see some elderly couple that has worked hard in a rural area and accumulated a little money, then to see them wiped out, that's pretty bad.

Fortunately, the couple that I talk about here that lost the $41,000, that didn't liquidate them. They, fortunately, were well off. But, $41,000 is a pretty good chuck of money for a year and 9 months to be liquidated.

Mr. DINGELL. Mr. Walton, how do the agents pick out the people to whom they are going to sell these policies?

Mr. WALTON. My experience has shown that they use four methods, Mr. Chairman. First of all, I think I have it listed as number three in my statement. That is, they exchange these unscrupulous salesmen kind of like a network. They exchange these lists among themselves. Also, they get them from leads.

In our part of the State, they have these flyers that come out in the Sunday papers and magazines. Ms. Burns here has some that I have seen something similar to. They come out in newspapers that the people fill out, and then they mail them in with certain personal data that these door-to-door salesmen follow up on.

Another way they do it is through 800 telephone numbers, TV and radio ads, and the fourth way they do it is ask their customers if they know of somebody else, some relative or someone that might use their service. In the case of the couple here, I don't know how they did it because this guy was out of the metropolitan area of Dallas/Fort Worth. The way he got onto these people was apparently a newspaper article about them buying a new home, a local thing. How he got onto that, I don't know. I have not been able to determine that.

Mr. DINGELL. Mr. Gartner and Mr. Walton, you have indicated that one of the devices used by yourselves and by others is the threat or actual carrying out of criminal prosecutions in these matters.

First of all, is criminal prosecution the best method of addressing this kind of problem?

Mr. GARTNER. From my standpoint, any time that you get lawyers involved, that should be the last point. Criminal prosecution, obviously, acts as a deterrent. I think that effective legislation and the threat of criminal prosecution would be a deterrent.

Mr. DINGELL. Criminal prosecution requires proof beyond a reasonable doubt. It is a heavy burden, it's costly, it is after the fact action to correct a wrong already done. The ability to address the wrongdoing is somewhat limited, and the powers of the court to address the specific problems of restitution are somewhat limited.

In addition to that, the caseload of prosecuting attorneys in the different counties around the country varies greatly and their resources do too. In most instance, I note from back home, the resources of the prosecutors are somewhat strained; am I incorrect in those thesis?

Mr. WALTON. That is correct, yes.

Mr. GARTNER. I think as a practical matter, criminal prosecution is not available now. When we began this case, we felt criminal prosecution was not an option for a number of reasons. First of all, most of the victims because of their ages, could not testify. Second of all, California had——

Mr. DINGELL. They are poor witnesses because they have bad memories.

Mr. WALTON. That is not unique to insurance. It is unique to any type of case in which the elderly is victimized, whether it is purse snatching or roofing scams or whatever. California nor the Federal Government has any clear standards defining how much insurance is too much.

So, you can't go a prosecutor and can't come to my office and say that this person has bought four policies, not three that is permitted so prosecute. Likewise, the California twisting statutes are no good, because we can't set two policies side-by-side and say the person should not have been moved from policy one to policy two.

There will always be some variations with the 200 supplements that are on the market. An insurance agent could always point to minor variations as justification for moving a person from one policy to another. If we had standardization, a prosecutor could set two policies down side-by-side and see that the two are comparable, see that the second one costs more, and then have a basis for prosecuting for unnecessarily selling the second policy. That doesn't exist now.

Mr. DINGELL. Ladies and gentlemen, the time of the Chair has expired. I want to thank you for your very helpful testimony to the committee. We are very appreciative.

The Chair will recognize the gentleman from Oregon for additional questions.

Mr. WYDEN. Thank you very much, Mr. Chairman. I do very much appreciate the additional time of the Chair.

Ms. Burns, in some jurisdictions, aren't agents required to fill out special disclosure forms that would show how the policy they are trying to sell would fill in the gaps in Medicare?

Ms. BURNS. Yes, they are. There are standard disclosure forms. Those, again, are quite confusing for people with minor variations in these policies. The companies are also required to send a form to the policyholder indicating that the person intended to replace an insurance and asking for a signature on a document that says that they understand the implications of that replacement.

While the company is required to send it to the policyholder, there appears to be no requirement that the form be returned. In many of the cases that I have seen, those forms have arrived but they are completely blank and in the papers of the policyholder.

Mr. WYDEN [presiding]. Even in jurisdictions where there is a disclosure requirement along the lines of what you are talking about, compliance or failure to comply is pretty widespread?

Ms. BURNS. It is. But I can tell you that we hear less about these sorts of abuses in States where standardization has been legislated.

Mr. WYDEN. One other question with respect to this loss ratio issue. Again, there are companies with very high loss ratios, and it would seem to me to be quite a deterrent to some of those who

haven't come up to the standards if the word got out among senior citizens and their advocates who had the low loss ratios.

I haven't seen much disclosure of the companies with low loss ratios among senior citizens and their groups. Is this getting to be a problem?

Ms. BURNS. I think that is one piece of information that people need. It is like any other piece of information and can be distorted to mean anything that the person who is doing the selling wants it to be.

I think Mr. Gartner maybe has a comment on loss ratios.

Mr. GARTNER. Very briefly. The concept of loss ratio is an important one that anybody can understand, that there be a relationship between premiums paid and money that is paid out in claims. Unfortunately in practice, loss ratio now is not comprehensible. It is not understandable by any ordinary people.

When we began in California, there were pages of loss ratio regulations that were simply beyond the capacity of ordinary people to understand. I believe that the insurance commissioners and regulators ought to be able, in plain English, to define loss ratio in a way where it could be used to compare policies. Right now, it doesn't exist. You will find many explanations for why loss ratio cannot be used.

Mr. WYDEN. Would you think it would be helpful Mr. Gartner, if this committee took it up with the NAIC for example, by way of saying that we believe it would be helpful to simplify the loss ratio rules and make them more understandable?

Mr. GARTNER. I think it would be helpful. I will tell you as a practical matter, I bet you get lost in the thicket of actuarial gobbledygook that is going to make it impossible. The other areas that we have talked about, defining the numbers of policies, extending that definition to all forms of health insurance, leveling out commissions, standardizing insurance policies, those have much more likelihood of being the subject of realistic legislation than in my view, loss ratio does.

Mr. WYDEN. One other question with respect to public education, and perhaps I will start with you, Ms. Burns. I probably get a question every few weeks from somebody who is in their 30's or 40's who is a lawyer or an accountant, who will call me up and they will say, I have been working with my mom or dad's Medicare supplements. They say, this stuff is incomprehensible. They say that you have been involved in it, and what is your advice.

Aren't there some limits to what we can accomplish with public education programs, as long as so much of this material is couched in terms that just seems almost incoherent to people?

Ms. BURNS. I think we can do a lot, if we look at the issues that Don just identified, one of which is standardization. Standardization would go a long way to helping consumers make intelligent choices. I would also like to point out to the committee that when seniors use money from limited resources to buy all the duplicate coverage that you see here and run the risk of impoverishing themselves by doing that, we as taxpayers are going to pick up the results of that.

They have just so much money to last them the rest of their lives. If it is being stolen from them through the sale of a product

such as you see represented on these charts, we as taxpayers will ultimately pay the price of that through the Medicaid program when those people become impoverished.

Mr. WYDEN. You all have been helpful. As I said in my comments, I think what is most exasperating about this is that people like yourself, Ms. Burns and our panel members, have been at this literally for 20 years. Myself, not quite as long, and we still have these very significant hurdles to overcome. You all have been very helpful in terms of documenting the problems.

Let me recognize my colleague from Pennsylvania, if he has any additional questions.

Mr. WALGREN. I have nothing at this time.

Mr. WYDEN. Unless our panel members have anything further that they would like to add, we will let you go with our thanks. We will be working with you in the day's ahead.

Our next panel will consist of John Hildreth, Executive Director of the Consumers Union of Texas, Mr. James Firman, President of United Seniors Health Cooperative, Mr. James Corcoran, Superintendent of Insurance for the State of New York, Mr. Earl Pomeroy, President-Elect, National Association of Insurance Commissioners, and Commissioner of the State of North Dakota.

We welcome all of you to the subcommittee. As you probably heard, it is the practice of the Subcommittee on Oversight and Investigations to swear all witnesses. Do any of you have any objection to being sworn today?

[No response.]

Mr. WYDEN. Please rise and raise your right hand.

[Witnesses sworn.]

Mr. WYDEN. It is also your right, in accord with the committee rules, to be represented by counsel. Do any of you desire to be represented by counsel today?

[No response.]

Mr. WYDEN. I also note the presence of the committee rules at the subcommittee table. You have the right to have those throughout your appearance today. We will make your prepared remarks a part of our hearing record in their entirety. If, in the interest of time, you could perhaps summarize your concerns in 5 minutes or so, that would be very helpful just to keep things moving along.

Mr. Pomeroy, we welcome you. The Chair has enjoyed working with you in the past. Why don't you begin the panel's testimony. We do need to get that microphone on for you, Mr. Pomeroy and for our other witnesses. Please proceed.

TESTIMONY OF EARL R. POMEROY, VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; JAMES P. CORCORAN, SUPERINTENDENT OF INSURANCE, STATE OF NEW YORK; JOHN L. HILDRETH, DIRECTOR, SOUTHWEST OFFICE OF CONSUMERS UNION; AND JAMES P. FIRMAN, PRESIDENT, UNITED SENIORS HEALTH COOPERATIVE

Mr. POMEROY. I am Earl Pomeroy, Insurance Commissioner of North Dakota and Vice-President of the National Association of Insurance Commissioners. A brief word of correction, Mr. Chairman.

I am not President-Elect. I will need to stand for election to that position in December, which I intend to do.

Mr. WYDEN. Let the record show your title correctly.

Mr. POMEROY. Thank you. I would also like to introduce Carol Olson, Senior Counsel of the National Association of Insurance Commissioners, and she will be providing technical support during the question and answer period this morning.

Mr. WYDEN. So, she will be here to represent you as counsel, in effect?

Mr. POMEROY. Or, she can testify directly, Mr. Chairman. Carol Olson, as our staff member, has information regarding State activity that goes beyond my own knowledge.

Mr. WYDEN. She has been sworn, and that will be appropriate for her testimony. Please proceed.

Mr. POMEROY. I want to thank you for the opportunity to appear before you for purposes of presenting testimony regarding the status of State regulatory activity on Medicare supplement insurance. I want to applaud Jim Firman, appearing on this panel, whom I have worked with and have great respect for his work, as well as the Consumer Advocates and very effective representatives of senior citizens that appeared on the preceding panel.

We have been in frequent contact with the committee staff in recent months, Mr. Chairman. As State insurance regulators, we share your and committee's sincere concern for elderly health insurance consumers, and we also share your outrage at the abuses which occur in this marketplace.

Providing meaningful consumer protection to the Medigap insurance market is a priority issue with me and each of my fellow insurance commissioners. In the prepared testimony and in the voluminous information the NAIC has submitted to your staff, we have attempted to document the breadth of State regulatory activity occurring on this issue across the country.

In my oral testimony, I will provide summary information on the following aspects of this marketplace. I want to bring you up-to-date on the present status of the regulatory framework after the passage of the catastrophic care amendments to the Medicare program. Second, I want to indicate what we are seeing as initial pricing trends impacted by the first year's implementation of the Medicare revisions.

Thirdly, I will give you information regarding the rate review and loss ratio monitoring which is presently taking place in the States. And, finally, indicate ongoing regulatory responses to consumer abuses in the advertising and sale of Medicare policies.

The Medicare Catastrophic Coverage Act of 1988 provided that the NAIC would develop revised minimum benefit standards for Medicare supplement insurance, and that the States would be required to adopt the NAIC standards or standards more stringent within 1 year of the NAIC adoption.

The NAIC did develop the revised standards within 90 days of the passage of the Catastrophic Act. Proposals regarding these revisions are pending in every State and have been passed in a number of States. The NAIC expects that all States will complete their revisions by September 20, 1989, within 1 year of the NAIC's adoption of the revised Medicare supplement standards.

As you pointed out, Mr. Chairman, it has been a major transition in the marketplace. We have brought on board, we think in a timely and proactive basis, the new regulatory standards which will keep this from being a period of marketplace abuses.

There has been some inquiry, Mr. Chairman, why the premiums have not gone down right across the board, in light of the expansion of the Medicare program due to the Catastrophic Act. As it turns out, States are reporting a wide variance in premium adjustments on existing business. Decreases of as much as 35 percent or increases up to 62 percent have been seen in the States and granted.

Premium adjustments vary, and they can be explained on a variety of bases, which is outlined in some detail in the printed testimony. I will tell you that the primary reason Medicare supplement insurance costs are increasing appears to me to be because of increased utilization and higher prices for medical services.

Medicare spending for physician services increased at an annual rate of 13 percent between fiscal year 1981 and 1987; the growth between 1986 and 1987 alone was approximately 18 percent. The very same forces that are driving up Part B costs in the Medicare program are also driving up the costs of Medicare supplement insurance.

As to State activity and review of rates and loss ratios, rates may vary across the country but the minimum loss ratios are uniform nationwide. Each State, therefore, operates under the same loss ratio standards unless a State would choose to make the minimum standards even more stringent.

The NAIC model, amended in December of 1987, requires a filing of rates, loss ratio information, and supporting documentation to be made in each State where a policy is marketed. The NAIC maintains that rates and loss ratio information must be used in conjunction with one another. The NAIC has developed a reporting form as of 1985, to track loss ratio information. As indicated in the preceding panel, it is a very difficult thing to technically assess an accurate loss ratio reading.

The NAIC is continuing to examine, on an ongoing basis, the effectiveness of our reporting form. All States are presently requiring it, and they will be reporting to us on their usefulness.

As to market conduct concerns, Mr. Chairman, I am appalled that any insurance company or insurance agent would attempt to prey upon the fears and frailties of the elderly. Unfortunately, the same base and vile instincts which have brought con artists selling anything from shares in an imaginary gold mines to overpriced aluminum sidings to the doors of senior citizens of this country are also found in the insurance industry.

There is no greater regulatory challenge than attacking this scourge of the insurance marketplace. Our attack is based on three points. First, we identify the abusive practice and, if not already prohibited, we move an appropriate regulation or statute into place.

Second, we prosecute complaints to the fullest extent of our administrative authority, which ultimately may involve a fine or revocation of a license. And, we cooperate with State or Federal law enforcement agencies when criminal proceedings are appropriate.

Mr. Chairman, any activity this committee may care to undertake that might make criminal prosecution of some of the more egregious agent offenses that have been revealed this morning, we would applaud and highly support that activity as the National Association of Insurance Commissioners.

Thirdly, under the rationale that an informed consumer will not be a defrauded consumer, State regulators have expanded insurance regulatory services into an active effort to educate insurance consumers on the pitfalls of the marketplace. While we acknowledge and abhor the fact that marketplace abuses are occurring, it is important to place these abuses into perspective as compared to the marketplace in toto.

Last year, State insurance departments reported handling nearly one-half million complaints. A breakdown of that data submitted by the 21 States reveals that health insurance complaints constitutes roughly 17 percent of the total number received. Of 11 States breaking out specifically Medigap policy complaints, these complaints have run about 10 percent of the complaint total received by those insurance departments.

In the 9 years since the adoption of the Baucus minimum standards and in response to a lot of hard work by insurance regulators, we believe the marketplace has seen considerable improvement. I am not saying that there are not abuses still occurring, but the marketplace has improved we believe.

In response to regulatory concerns, the following specific prohibitions have been adopted. Duplication of coverage by agents is a concern that has been addressed in various jurisdictions. State departments, on an ongoing basis, impose revocation, suspension, fines, and other penalties on agents for this activity. Twisting the practice of persuading an individual to roll their policy over so an agent can access first year commission has been a difficult regulatory problem.

Two States have prohibited companies replacing existing coverage from instituting a new preexisting waiting period. That is presently being considered by the NAIC to be included as part of the model of prohibition. The NAIC has also addressed commission structure, relative to one company replacing a policy with another product that company may issue. We prohibit first year commissions from being paid to the agent on that activity.

Misrepresentation is a prohibited activity under the NAIC Unfair Trade Practice Act, which has been adopted by all States. Other areas that we have addressed, co-lead advertising, celebrity advertising, we also have developed a nationwide computer base regarding problem agents.

Mr. Chairman, I will be happy in the question and answer period to detail some of our activities in these areas. Thank you.

[Testimony resumes on p. 57.]

[The prepared statement of Mr. Pomeroy follows:]

TESTIMONY

OF THE

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

ON MEDICARE SUPPLEMENT INSURANCE

Mr. Chairman, I am Earl Pomeroy, Insurance Commissioner of the State of North Dakota and Vice President of the National Association of Insurance Commissioners (NAIC). The NAIC is a non-profit association whose members are the 50 insurance officials of each state, the District of Columbia, Guam, American Samoa, Puerto Rico and the Virgin Islands.

Thank you for the opportunity to appear before you and the members of this subcommittee regarding the status of state activity on Medicare supplement insurance. The purpose of this testimony is to furnish information which you have requested orally through your staff counsel on these issues:

1. State Activity
2. Pricing of the Medicare Supplement Policies
3. Nature of Rate Review and Monitoring of Loss Ratios
4. Premium Adjustments
5. Interstate Activity
6. Consumer Abuses

We are also here to respond to specific comments you have made recently concerning the pricing of the policies and perceived consumer abuses and to answer any questions you may raise today.

State Activity

Implementation of NAIC Model Provisions

Because the Medicare Catastrophic Coverage Act of 1988 expanded benefits for Medicare beneficiaries, there are fewer benefits for Medicare supplement insurers to cover. As a result, there are strict prohibitions in both the federal law and in the NAIC models against duplicating the benefits that are now covered by Medicare. The NAIC model which was specifically designed to require insurers to eliminate such duplications is the NAIC Transition Rule. This Rule, which was endorsed by the Congress, also requires insurers to notify existing policyholders of the changes in the Medicare program and in their Medicare supplement coverage and to make appropriate premium adjustments.

In addition to requiring compliance with the Transition Rule, the Medicare Catastrophic Coverage Act of 1988 provided that the NAIC would develop revised minimum benefit standards for Medicare supplement insurance and that the states would be required to adopt the NAIC standards or standards more stringent within one year of NAIC adoption. The NAIC did develop revisions to its standards within 90 days of passage of the Catastrophic Act.[1] The states, in a very short timeframe, have implemented those revisions. In fact, 10 states completed their revisions by year end 1988.[2] Thus far in 1989, twenty-

four states have amended either their regulation or their statute.[3] Proposals are pending in every other state, in some form or another.

Certification

The states which have completed their revisions are now submitting their Medicare supplement programs to the Supplemental Health Insurance Panel, which was established under the original Baucus amendment, for certification.[4] As of March 21, 1989, 13 states were conditionally approved by the Panel.[5] Conditionally approved means that the state is in full compliance, but approval is conditional pending final action by the state. The states' proposals other than those 13 are in various stages of review by the Health Care Financing Administration staff. The NAIC expects that all states will complete their revisions by September 20, 1989, (one year after NAIC adoption) and will either become or will remain certified.

Pricing of the Medicare Supplement Policies

Mr. Chairman, you have inquired why Medicare supplement insurance premiums appear to be increasing after passage of the Catastrophic Act. Because the Catastrophic Act increased Medicare benefits for it beneficiaries, it was certain that there would be fewer Medicare supplement insurance benefits to insure and as a result, it was thought that refunds or credits would be due to existing policyholders. As it turns out,

however, not all existing policyholders are receiving refunds. In fact, it has come as a surprise to some that the premiums are actually increasing.

First I must point out that there is a wide variance in the premiums on these existing policies (those in existence on January 1, 1989). The states report that the Catastrophic Act, by itself, has generally caused premiums to decrease slightly because it required insurers to eliminate benefits now covered under the Medicare program. However, other factors, such as the timing of the premium adjustment, the increase in utilization and higher prices for medical services, the length of time which has elapsed between premium increases, recent loss ratio performance, and addition of new minimum benefits have all contributed to a net increase in premiums on the existing policies.

As I mentioned, the Catastrophic Act resulted in only a slight decrease in premiums. For the year 1989 the changes in the Medicare program affected Part A (hospital) services only: inpatient hospital services, skilled nursing facility (SNF) care and blood. In 1989, the Medicare program was expanded to cover an unlimited number of days in the hospital (after a $560 deductible). The program was also expanded to eliminate the prior hospitalization requirement for skilled nursing facility care and now covers 100 percent of costs after the first 8 days of skilled nursing facility care (up to 150 days).

Therefore, these items described above which are now covered under the Medicare program are to be eliminated from the existing policies effective January 1, 1989, pursuant to the NAIC Transition Rule.[6] However, because these new benefits are not that extensive, refunds may be slight or may not occur at all.

Premium adjustment information has been filed with the departments and states are now examining or approving (if a state has prior approval authority) rate increases or decreases on the policies which have previously been approved and are in the hands of policyholders on January 1, 1989.

Departments are also examining the brand new policy filings to which the NAIC's revised minimum benefit standards apply, once adopted. The significance of the revised benefit standards is that they require insurers to include certain additional benefits in any new policies. The additional benefits which are required in 1989 are:

1. Either all or none of the Medicare Part A deductible ($560),
2. Coverage for the first 8 days of skilled nursing facility (SNF) care ($25.50 per day = $204), and
3. Coverage for the cost of the first 3 pints of blood (difficult to estimate, but approximately $50 per pint = $150).

It is these new benefits that are taken into account when

reviewing premiums for the Medicare supplement policies offered in 1989. However, it must be noted that some companies offered some of the above items such as the deductible, for example, even though they were not required to do so prior to 1989.

Nature of Rate Review and Monitoring of Loss Ratios

The NAIC models were amended in December of 1987 to require a filing of rates and loss ratio information. The NAIC maintains that the two must be used in conjunction with each other. The NAIC further emphasizes that loss ratios are only one regulatory tool used to assess the appropriateness of returns to the policyholders. Mr. Chairman, the current level of rate review varies among the states, but the majority of states mandate at least a filing of Medicare supplement rates even though the NAIC models did not require it prior to 1987. A more stringent approach used by some states is prior approval of the rates by the commissioner.[7]

In December of 1987, the NAIC added significant requirements to its Model Regulation regarding monitoring of loss ratios. Those revisions require: filing of loss ratio information, compliance with actual loss ratios, and application of the 75 percent loss ratio to direct mail groups, which were previously allowed to meet the 60 percent minimum.[8]

Mr. Chairman, the NAIC has recently devoted attention to the monitoring of loss ratios as is evidenced by the new model

requirements and by the development of a loss ratio reporting form. The reporting form was developed in 1985 and we have collected information for insurance department usage for the years 1986 and 1987. We believe that by approximately August 1, 1989, we will have a report to release to this subcommittee and other interested parties on the 1988 data. The 1988 report will contain information submitted on a revised form which is due on June 30, 1989. The NAIC is examining on an on-going basis, the effectiveness of this reporting form. The states are reporting to us their opinions on its usefulness.

Premium Adjustments

States are reporting a wide variance in premium adjustments on the existing business. Premium decreases as much as 35 percent are reported on one filing and premium increases as much as 62 percent have been filed and/or granted. In Washington state, the reported increases vary from 4 to 10 percent. Many states indicate that the insurers are maintaining rates at the same level as last year, just to cover the increase in costs on the Part B coverage. Of the 15 commercial insurers selling Medicare supplement insurance in New York state, the spectrum of change ranges from a 12 percent decrease through a 62 percent increase on one particular filing. Of the Blue Cross/Blue Shield plans selling in New York, the percentage of change varies from a 23 percent decrease to a 16 percent increase. The health maintenance organizations selling Medicare supplement coverage in New York

have received increases ranging from 5 to 50 percent.

Arizona reports that it has approved rate increases averaging from 12 to 15 percent and commented that the increases have been based primarily on the rising medical costs paid under Part B and, to a much lesser extent, to the increase in the Part A deductible.

Kansas reports that of the 70 plus companies that sell Medicare supplement insurance in that state, the percentage change varies from a 38 percent decrease to a 52 percent increase (Appendix 8).

Illinois has reviewed increases of a moderate nature in the area of 5 to 10 percent.

In Pennsylvania and Montana, the states have reviewed an equal number of filings which have decreased, stayed the same or increased.

Utah indicates that little or no refunds have been made due to the increase in Part B costs. That state has witnessed a 3 to 7 percent increase on some of the filings.

Regarding the number of new policy filings, we do not have a countrywide total of policies approved to date, but we have some estimates furnished to us by some states. The NAIC is aware that in the state of Illinois for example, at least 25

filings have been [illegible]
stages of review.

Premium adjustments are varying widely on existing policies because of several factors:

1. The timing of the premium adjustment required by law may coincide with a normal request for a rate increase (at renewal). The savings obtained from revisions in Medicare coverage because of the Catastrophic Act may be more than offset by increases in the cost of providing the remaining coverages in the policy.
2. Medicare supplement insurance costs are increasing because of: (1) increased utilization and (2) higher prices for medical services. The Medicare program has witnessed sizable increases on Part B costs (physician services) which are attributed equally to volume and intensity and price increases, according to Dr. William Roper (Administrator, Health Care Financing Administration) before the House Committee on Ways and Means late last year. Medicare spending for physician services increased at an annual rate of 13 percent between fiscal year 1981 and 1987. Dr. Roper also pointed out in his testimony that the growth between 1986 and 1987 alone was approximately 18 percent. Presumably the same forces that are driving up Part B costs in the Medicare program ar

also driving up the costs of Medicare supplement insurance. With respect to the price of medical services, the Consumer Price Index (CPI) for physicians' services increased by 7.2% in the last year and 15.1% over the last two years. The CPI for hospital services increased by 9.3% in the last year and 16.9% in the last two years.

3. The insurer may not have requested or filed an increase for a lengthy period of time. If not, a premium increase is likely.
4. The insurers' recent loss ratio performance greatly affects the current pricing of the product. High recent loss ratios would necessitate a premium increase, while low loss ratios would permit a decrease. According to the NAIC's figures, the incurred loss ratio for individual Medicare supplement business increased from 76.5% in 1986 to 77.4% in 1987. The loss ratio for group business increased from 86.5% in 1986 to 88.3% in 1987.
5. At the same time that insurers are eliminating duplicate coverages on part A due to the Catastrophic Act, they also may be adding the new minimum benefits, such as the deductible, as well as other coverages not previously offered. Providing "first dollar" coverage such as the deductible ($560) can be particularly expensive.

Interstate Activity

You have inquired about the interstate impact on: the policy provisions, the rates and loss ratios, the advertisements, and agent activity.

The Policy

Much of the Medicare supplement business is sold on a group basis. This means that the group master policy which sets forth the minimum benefits is governed by one state law and many certificates of insurance are issued in other states under that master policy. In December of 1987, the NAIC made another significant revision to its model by requiring every insurer providing group Medicare supplement insurance to residents of a state to file a copy of the master policy and certificates used in the state.[9] This filing does not have to occur prior to providing insurance; it must be made within 30 days.

The filing requirement allows a commissioner to examine that policy and to request any information pertaining to the policy. The purpose of the requirement is to assist with consumer complaints on these policies. The extent of authority over a company based on this filing requirement must however be combined and examined in light of other applicable health insurance laws and unfair trade practices acts. Having access to the policy provisions is a helpful tool for resolving complaints. Often times no further inquiry is necessary beyond

an examination of the policy provisions.

Rates and Loss Ratios

Rates vary across the country, but the minimum loss ratios are uniform nationwide. Each state therefore operates under the same loss ratio standards (unless a state chooses to make the minimums more stringent).

Advertisements

The NAIC recommended well before passage of the Catastrophic Act, as an option, that states require filing of all Medicare supplement advertisements. The Catastrophic Act then codified this filing for "review or approval to the extent it may be required under state law." All states will incorporate this filing requirement into their law or regulation.[10] As a result, the states will be responsible for reviewing or approving all Medicare supplement advertisements, regardless of state of domicile, to the extent that state law so provides.

Agent Activity

Agent activity is within the jurisdiction of the commissioners who license the agents and various sections of the insurance codes are to be applied when agent misconduct is suspected and reported. A very common statutory example is the

provision listing the grounds for revocation or suspension of an agent's license, which grounds typically include misrepresentation, fraud, dishonest practices, and violations of unfair trade acts.

Consumer Abuses

Mr. Chairman, although you have alluded to "widespread" consumer abuses, you have not furnished us with specific instances where problems have been identified and have not been resolved by the states. We believe that the state departments have been responding to reported abuses and have been fielding complaints on a very routine basis. We know that last year the state departments handled over 400,000 complaints, or an average of 10,000 per department reporting. Because this figure includes complaints for all lines of insurance, we know that health insurance complaints are only a portion of this total. We know further that based on the data furnished by 21 state insurance departments, just 17 percent of the total number of complaints were health insurance related.

Eleven states specifically track Medicare supplement complaints. Of those 11, 8 reported that less than 10 percent of the complaints related to Medicare supplement insurance. Three states reported that the Medicare supplement complaints constituted slightly more than 10 percent.

Consumer complaint information is available to the public

in 46 states, but there are some restrictions applied in certain jurisdictions. Every state insurance department has professional staff assigned to consumer education/consumer protection activities. All states have formalized, step-by-step procedures for dealing with consumer complaints.

Turning to abusive practices with which we share your concern, we understand that you are referring to misrepresentation, duplication of coverage and twisting of business. You are correct in assuming that these agent abuses do occur, although the NAIC maintains that they occur to a much lesser extent than 9 years ago when the Baucus amendment was originally enacted or even 3 years ago because of the efforts of state insurance commissioners and the NAIC.

The NAIC does not believe that there are statutory impediments to addressing agent abuses. The state insurance departments, in addition to enforcing their own statutes and regulations, work with local authorities to enforce federal laws. A recent example is my own state which is submitting department records and furnishing testimony against an agent in a criminal prosecution. That agent's license was revoked by my department and the information we supplied assisted in this criminal prosecution.

Complaints

In evaluating whether there has been any lack of attention

by insurance commissioners, it is helpful to know how these consumer complaints originate. With Medicare supplement insurance, the majority of complaints are filed by a concerned relative who, after the sale or activity, examines what has happened and inquires about it. Another method of learning how consumers are abused is through seminars conducted by insurance department personnel for the elderly. Insurance department personnel investigate complaints arising out of personal contact with the elderly at these seminars. Insurance departments do not actively seek out complaints. They believe a very effective method of curbing abuses is raising the awareness of elderly consumers by alerting them, though seminars and written material, to certain basics, such as:

1. Know your agent,
2. Ask a relative to assist with the purchase of insurance,
3. One policy may be enough,
4. Be aware of pre-existing conditions,
5. Remember the free-look provision,
6. Consult your insurance department if you have questions, and
7. Be aware of agents who try to replace your current coverage with something "better."

Another consideration which is important in this discussion and a reason why state departments believe so strongly in consumer education is the nature of the elderly and their proclivity to abuse. Those over age 75 are particularly

susceptible to agent misconduct.

Educational Efforts

As I mentioned above, the NAIC and the states believe that education is one of the most effective tools used to curb agent abuse. There are a number of efforts in addition to those mentioned above which are employed on a regular basis by the states and should be highlighted here.

All states require delivery of the NAIC/HCFA Buyer's Guide for Medicare supplement insurance. In addition, many departments, such as North Dakota, Maine and Mississippi are involved in the seminars mentioned above to educate consumers about Medicare supplement insurance. Kansas reports that in over 102 speeches were recently made by department staff, mostly to seniors. Ohio has established a speakers' bureau within the insurance department. The state of Washington implemented a SHIBA (Seniors Health Insurance Benefits Advisors) program which assists in educating consumers. At least 10 other states have implemented a comparable one-on-one counseling program: Idaho, Illinois, Maryland, Massachusetts, Missouri, New Jersey, North Carolina, Ohio, Oregon and Vermont. In California, the Health Insurance Counseling and Advocacy Program, funded by the state insurance department and administered by the Department of Aging, hires professionals to educate seniors.

Public service announcements have been produced for airing on TV and radio stations. Texas is an example. In Wisconsin, seminars are conducted by the insurance department to train county benefit specialists in local welfare offices concerning insurance practices.

In summary, Mr. Chairman, we believe the states are doing an effective job of educating senior citizens about Medicare supplement insurance. We further believe that states have the statutory and regulatory means to sanction abusive conduct. We do, however, welcome you to share the findings of your investigation which reveal otherwise.

Duplication of Coverage

Duplication of coverage by agents is a concern that has been addressed in various jurisdictions by legislation prohibiting the conduct. State departments, on an ongoing basis, impose revocations, suspensions, fines and other penalties on agents for this activity.

"Twisting" or Replacement of Coverage

Twisting is a practice which is illegal in many states. It is the practice of persuading an individual to drop existing coverage and replace it with a new policy containing similar benefits. One problem with replacing coverage is that the new

coverage will contain pre-existing condition requirements that must be satisfied and will subject an individual to brand new deductibles, as an example.

A frequently-cited reason for twisting is that commissions on new policies are much higher than for renewals. The NAIC has addressed this aspect of twisting by adding a restriction on payment of replacement commissions.[11]
The state of Oregon recently reported that its Office of Consumer Advocacy is introducing legislation, S.B. 190, which addresses twisting.

Misrepresentation

Common agent misrepresentations in the Medicare supplement area are statements that a policy covers 100 percent of costs not picked up by Medicare. Misrepresentation is a prohibited activity under the NAIC Unfair Trade Practices Act which has been adopted by all states.

Cold Lead Advertising

Cold lead advertising has recently been addressed by California, Florida, Kentucky, North Carolina, Oregon, Texas and Washington. This practice is used to obtain the names of potential insurance applicants through the use of "lead cards" mailed to senior citizens. The cards are typically mailed by a non-insurance related entity (some are linked to insurance

companies) using words to imply that the entity is governmental or non-profit. The recipient is instructed to return the card for information concerning Medicare supplement and the recipients' names are sold to insurance companies and agents. Kentucky's approach was to issue a bulletin to all life and health insurers in Kentucky regarding the use of lead cards. The NAIC Rules Governing Advertisements of Medicare Supplement Insurance discussed below apply to lead-generating devices.

Celebrity Advertising

The states' concern over inappropriate celebrity advertisements and other market abuses led the NAIC to adopt Rules Governing Advertisements of Medicare Supplement Insurance. Although many of the provisions contained in this model had previously been located in the NAIC Rules Governing Advertisements of Accident and Sickness Insurance, the NAIC believed it important to separate and enhance the provisions that were designed to control Medicare supplement abuses.

The rules specifically address celebrity advertising by requiring disclosure of the fact of a financial interest of the spokesperson. The rules require certain claim data to be available for inspection when a testimonial refers to benefits received under a policy. The rule further prohibits testimonials which do not correctly reflect the current practices of an insurer or which are not applicable to the policy or benefit being advertised. An advertisement may not state or imply that an insurer or policy has been approved or

endorsed by an individual, group of individuals, society, association or other organization, unless that is a fact and unless any proprietary relationship is disclosed.

Other NAIC/State Activity

Two other regulatory mechanisms deserve mention. One is the NAIC's Regulatory Information Retrieval System (RIRS) which collects enforcement actions taken against agents and companies. The information, which reflects recent license revocations, suspensions and fines, is submitted to the NAIC by the state insurance departments and is now available to them "on-line" through our computer system.

Second, 92 percent of the states perform compliance examinations and 62 percent regularly hold market conduct examinations which include a review of rating of policies, claims handling, advertising and policyholder service.

Conclusion

Mr. Chairman, I hope that this furnishes you with the information you were seeking. The NAIC shares your concerns over the increasing premiums and the perceived consumer abuses. However, we do not believe that more federal regulation in this area will solve either of these concerns. We would be interested in discussing the specifics of the abuses your investigation has identified so that we can work together toward an appropriate response.

Thank you.

FOOTNOTES

[1]The NAIC held a special plenary session to adopt these revisions on September 20, 1988. The NAIC revised its **Medicare Supplement Insurance Minimum Standards Model Act** and its **Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.**

[2]Kansas, Massachusetts, Mississippi, Nebraska, New Mexico, Ohio, South Dakota, Texas, Washington and Wisconsin.

[3]Alaska, Arizona, Arkansas, California, Colorado, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Minnesota, Nevada, New Jersey, New York, North Dakota, Oregon, Rhode Island, South Carolina, Tennessee and Utah.

[4]The Supplemental Health Insurance Panel (SHIP) consists of the designee of the Secretary of Health and Human Services, Ms. Barbara Gagel, chair, and 4 insurance regulators: Director John Washburn (Illinois), Commissioner Roxani Gillespie (California), Commissioner David Levinson (Delaware) and Commissioner Andrea "Andy" Bennett (Montana).

[5]Arizona, California, Florida, Illinois, Iowa, Kansas, Nebraska, New Mexico, North Dakota, Oregon, South Carolina, Utah and Washington State.

[6]Model Regulation to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions. This rule primarily requires insurers to: (1) eliminate all duplications of coverage, (2) send notices to policyholders, and (3) make premium adjustments.

[7]At least 16 states require prior approval of Medicare supplement insurance rates. The other states generally employ a file and use or use and file approach.

[8]See Section 5 of the Transition Rule and Section 9C of the Model Regulation.

[9]See Section 5A of the Model Act and Section 10 of the Regulation.

[10]See Section 8 of the Model Act and Section 14 of the Model Regulation.

[11]See Section 11 of the Model Regulation which prohibits compensation for replacement with the same company.

Mr. WYDEN. Mr. Pomeroy, thank you very much. We have a vote on the Floor. We are going to break for 10 minutes, and get right back to this. I will make this vote and return very quickly.

[Brief recess.]

Mr. WYDEN. The subcommittee will come to order. Why don't we move next to Mr. Corcoran of the State of New York. We welcome you, Mr. Corcoran.

TESTIMONY OF JAMES P. CORCORAN

Mr. CORCORAN. Thank you. Many of the things I have to say, of course, follow with Mr. Pomeroy's statements. I will try to paraphrase as quickly as possible my written statement, and address some of the questions that are obviously being raised about how the regulators are approaching some of the obvious problems.

We have recently, on October 7, 1988, promulgated an Eighth Amendment to our Regulation 62, which establishes minimum standards for supplemental insurance. The Medicare supplemental insurance in New York State has been an issue which we have been dealing with for a long time. The approach we have taken, Mr. Chairman, is disclosure to the public in general.

We issue annually about 60,000 booklets. I believe that you have a copy of the booklet in front of you, which lists in the back of the booklet, a very comprehensive description of each policy issued by each company and, of course, the premium structure. We also require at the time of the sale, that a notification be given to the prospective purchaser that more than one policy might not be needed.

Prior to coming here, I checked with my Consumer Complaint Bureau which is, of course, really the operation that we use to find out where the public concerns really are. We have had approximately 775 statewide complaints regarding supplemental health insurance policies, not necessarily Medicare, out of a total of about 75,000 complaints that we get annually that we get.

It is not an issue in the State that we feel is one of the higher issues, because of our efforts which have included going to many senior citizen forums, sending out staff, education purposes and disclosure purposes. We think the booklets and the outreach program have had a very positive impact.

As you know, the Federal law placed the NAIC in a basic responsibility for establishing new minimum standards for Medicare supplement insurance policies for a transition period. Our actions started taking place within that transition period. We soon intend—we will be holding hearings very soon to finalize additional actions regarding Medicare supplements, reviewing some of the issues raised here regarding standardization and forbidding the sale of one policy and other issues, that I am sure will be raised by the public.

New York has two notable exceptions from the NAIC standards which were adopted in our new standards. One, the establishment of New York of minimum benefit standards only for 1 year, since we will be having subsequent hearings. The standards that we have right now regarding loss ratios, 65 percent for individual policies and 75 percent for group policies.

We chose to establish minimum standards for Medicare supplemental policies only for 1 year, for 1989, so that prior to 1990 the insurance department would have an opportunity to review and evaluate suggestions and recommendations from consumers and those raised here today. As the Medicare benefits increase to 1990 and existing Medicare supplement benefits decrease, the question certain arises as to whether Medicare supplement coverage should continue in its present form.

The possibility exists that at least some long term care benefits may be an appropriate addition to future Medicare supplement policies.

While the insurance department receives some opposition from insurers, the requirement that Part A deductible be covered under the Medicare supplement contract, the failure to require such a standard appeared in the insurance department to leave little to supplement on the Part A. The department also took note that most existing Medicare supplement contracts in New York already provide for coverage in Part A deductibles.

In particular, there major issues relate to existing policies that were addressed by the NAIC and the insurance department and our regulation; non-duplication of coverage, which was discussed, notice requirements and premium adjustments. Advertising, of course, is something we should also be concerned about in insurance. Endorsements, which I discuss in my written paper, at the present time our Regulation 34 contains a section which relates to testimonials or endorsements by third-parties.

Many commissioners are very offended of those who especially watch television at 2:00 o'clock in the morning for some strange reason. When you see these celebrities up there smiling and telling people I am your friend, buy these products, most of which are not licensed in my State.

In addition to the requirements that statements made in testimonials be considered as statements by the insurer, it also requires that the person making the testimonial reveal any financial interest in the insurer and any compensation received for making the testimonials. I presume those stars went on a heyday when they were making big bucks and didn't invest their money appropriately. I don't know for what other reason they would be doing these things at 2 a.m.

Insurance Department Regulation 34 also requires that an advertisement of a Medicare supplement policy must contain a statement that the policy meets minimum standards for Medicare supplement insurance, as defined by the Department. Now, you must distinguish when you talk about these issues, Medicare supplement policies from other limited benefit policies, as the prior panel pointed out.

Replacing of existing health insurance is a problem and the compensation system is one in the way of twisting. In our own Regulation, replacement occurs and the agent's compensation must generally be limited. Prior to December of 1988, almost all insurers writing Medicare Supplement in New York must submit to approval, any riders eliminating duplication of benefits.

You can read the rest of the testimony. What I have also done though, and I will provide you with an additional statement, re-

garding our amended regulations requiring that appropriate premium adjustments are necessary to produce and expected loss ratio, at least as great as that originally anticipated. If we find companies have not met the loss ratio expectation of 65 percent in individual and 75 percent in group, we make them refund or increase benefits.

The issues that were also raised by the group here, and I think that it is important that we discuss them very quickly, regarding agent abuses. What we do in New York, of course, agent abuse has been limited I think to a great extent, by the disclosure efforts of the department and by the Medicare supplement booklet. They have been relatively isolated instances.

When we do find these instances, we have fined many times or have taken the license. Also at the time of the sale, the agent must state—they must be given a sign statement by the prospective insured that I have reviewed the current health insurance coverage of the applicant and find the additional coverage of the type and amount applied for is appropriate for the applicant.

This way, we have something in writing by the agent if we find that an inappropriate sales has been made, to take the agent's license if abusive enough or to fine him heavily. In addition, New York requires that Medicare supplement insurance policies contain a provision permitting the insured a 30 day period to surrender the policy and obtain a refund.

As far as loss ratios, we have discussed that. We can go into that further. For your information, we are now looking at the issues of whether or not we should limit the sale to one policy, standardizing the policy, making two or three standard policies. We will be having a hearing in the State of New York regarding that issue.

This, to date, has been a relatively successful effort on our part to control these abuses. Thank you very much.

[The prepared statement of Mr. Corcoran follows:]

STATEMENT OF JAMES P. CORCORAN

I am James P. Corcoran, Superintendent of Insurance of the State of New York. I welcome the opportunity to appear before the U. S. Senate Committee on Energy and Commerce.

GENERAL BACKGROUND ON MEDICARE SUPPLEMENT INSURANCE

Medicare supplement insurance, which is the subject of this hearing, has long been a priority matter of the New York State Insurance Department. Since 1980 the Insurance Department, in accordance with the provisions of Section 3218 of the New York Insurance Law, has established minimum standards for the form, content and sale of Medicare supplement insurance in New York State. On October 7, 1988, the Insurance Department promulgated the Eighth Amendment to Insurance Department Regulation 62, establishing new minimum standards for Medicare supplement insurance in New York in response to the enactment of the federal Medicare Catastrophic Coverage Act of 1988.

The Department's keen interest in Medicare supplement insurance is also reflected by the fact that each year the Insurance Department publishes a booklet entitled "Medicare Supplement Insurance in New York State" which sets forth information concerning Medicare, and general information concerning Medicare supplement policies, as well as a listing of each Medicare supplement policy being sold in New York with a summary of the benefits, underwriting information and premium rates. As many as 60,000 of these booklets are distributed each year in New York State.

One of the important bureaus of the Insurance Department is our Consumer Services Bureau, which handles complaints and inquiries from the public concerning all types of insurance matters. During the year 1987, the total number of complaints registered with the Insurance Department relating to Medicare supplement insurance was approximately 775 statewide. These complaints are reviewed by our examiners, the insurance companies involved are contacted or a Department investigation is commenced, with the ultimate purpose of resolving the consumer's complaint. In comparison to the complaints received by the Insurance Department concerning other types of health insurance, the Medicare supplement insurance complaints are relatively small. For example, the complaints made to the Insurance Department statewide relating to accident and health insurance other than Medicare supplement was approximately 7000 for the year 1987.

In an effort to inform the public and provide consumers with a better understanding of Medicare supplement insurance, the Insurance Department in addition to publishing and distributing its Medicare supplement booklet, sends speakers throughout the state to senior citizen centers and other organizations which provide services to the elderly. During this past year approximately two such speeches were given per month by examiners from our Consumer Services Bureau or attorneys from our Health and Life Policy Bureau.

NEW YORK'S NEW MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT INSURANCE

As I mentioned earlier, the Medicare Catastrophic Coverage Act of 1988, which made some significant changes in the benefits provided under Medicare beginning January 1, 1989, prompted the Insurance Department on October 7, 1988 to issue new minimum standards for Medicare supplement insurance in New York State.

As you know, Federal law placed on the National Association of Insurance Commissioners (NAIC) the basic responsibility for establishment of new minimum standards for Medicare supplement insurance policies and for transition rules from the old standards to the new standards. On September 20, 1988, the NAIC adopted new minimum standards for Medicare supplement insurance. The standards in New York, promulgated by the Insurance Department as the Eighth Amendment to Regulation 62, essentially adopt the NAIC standards but with two notable exceptions.

First, a brief statement of the minimum benefits for Medicare supplement policies established in New York for the year 1989:

-- Coverage of the Medicare Part A inpatient hospital deductible amount.

-- Coverage for the daily coinsurance amount of Medicare Part A eligible expenses for the first eight (8) days per calendar year incurred for skilled nursing facility care.

-- Coverage for the reasonable cost of the first three (3) pints of blood under Medicare Part A unless replaced in accordance with federal regulations.

-- Coverage of the 20 percent coinsurance amount of Medicare eligible expenses under Part B, regardless of hospital confinement, subject to a maximum calendar year deductible of $300 of such expenses and to a maximum benefit of at least $5000 per calendar year.

The two notable exceptions from the NAIC standards which were adopted in the New York standards are:

-- The establishment in New York of minimum benefit standards only for the year 1989 (the NAIC rules also establish standards for 1990).

-- The requirement that insurers cover the Medicare Part A inpatient hospital deductible amount (the NAIC rules would allow an insurer to cover none of the Part A deductible).

As the Insurance Department stated in the Eighth Amendment to the New York Insurance Department Regulation 62, we chose to establish minimum standards for Medicare supplement policies only for the year 1989 so that prior to 1990 the Insurance Department would have an opportunity to review and evaluate suggestions and recommendations from consumers, other governmental agencies, providers and insurers concerning the appropriate level of Medicare supplement insurance minimum standards for 1990 and beyond. As the Medicare benefits increase in 1990 and the existing Medicare supplement benefits decrease, the question certainly arises as to whether Medicare supplement coverage should continue in its present form. While at the present time long term care benefits are being provided by insurers separate and apart from Medicare supplement insurance, the possibility certainly exists that at least some long term care benefits may be an appropriate addition to the future Medicare supplement policies. Because of the obvious impact that a major change in Medicare supplement benefits and premium rates might have and recognizing that very little time was available from the date of enactment of the federal law until the effective date of new minimum standards for Medicare supplement policies in 1989, it seemed most appropriate to the Insurance Department to establish standards for only one year and give greater thought and deliberation to what should follow in future years.

While the Insurance Department received some opposition from insurers to the requirement that the Part A deductible be covered under a Medicare supplement contract, the failure to require such a standard appeared to the

Insurance Department to leave little to supplement under Part A. The Department also took note that most existing Medicare supplement contracts in New York already provided coverage for the Part A deductible.

While the Insurance Department was establishing minimum standards for Medicare supplement contracts for 1989, we were not unmindful that there was a need for rules to address the effect the federal legislation would have on existing Medicare supplement policies. In particular, three major issues relating to existing policies were addressed by the NAIC and the Insurance Department in our regulation, namely:

-- nonduplication of coverage

-- notice requirements

-- premium adjustments

The New York minimum standards regulation provides that no Medicare supplement insurance policy or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare. The regulation also requires that insurers, no later than 30 days prior to January 1, 1989, notify their Medicare supplement insurance policyholders of modifications made to their Medicare supplement insurance policies. The format and content of the notice to policyholders is set forth in the regulation.

In addition, the New York regulation requires insurers to file for approval by the Superintendent appropriate premium adjustments as a result of the benefit changes in the Medicare supplement policy.

ADVERTISEMENTS

The federal law also addressed the subject of advertising Medicare supplement policies by requiring advertisements for such policies to be

submitted to state insurance departments for review. In response to this federal requirement, the Insurance Department amended our existing Regulation 34 which sets forth rules governing advertisements of accident and health insurance and required that every insurer providing Medicare supplement insurance provide to the Superintendent, prior to its use, a copy of any advertisement for a Medicare supplement insurance policy intended for use in this state whether through written, radio or television medium. Such advertisement must comply with all applicable regulations and laws of this state. At the present time our Regulation 34 contains Section 215.8, which relates to testimonials or endorsements by third parties. In addition to requiring that statements made in testimonials be considered as the statements of the insurer, it is also required that the person making the testimonial reveal any financial interest in the insurer and any compensation received for making the testimonial. Reference in an advertisement that an insurer or policy has the endorsement of any particular individual or organization cannot be made unless that is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. Other provisions relating to testimonials are also set forth in the regulation and there are specific sections of the regulation relating to the form and content of advertisements, the prohibition of deceptive words, phrases or illustrations, the need to reveal in the advertisement any exceptions, reductions and limitations relating to policy benefits, as well as the necessity for disclosing policy provisions relating to renewability and termination. Insurance Department Regulation 34 also requires that an advertisement of a Medicare supplement policy must contain a statement that the policy meets the minimum standards for Medicare supplement insurance as defined by the Insurance Department and set forth the expected benefit ratio

for the policy. In addition, the advertisement must refer individuals to a consumer guide to health insurance for people eligible for Medicare which may be obtained from a local Social Security Office or from the insurer making the advertisement.

REPLACEMENT OF EXISTING HEALTH INSURANCE

In order to help assure that when individuals decide to replace existing health insurance policies with a newly issued Medicare supplement policy they do so only when it is in their best interest to do so, the Eighth Amendment to Regulation 62 contains a section setting forth rules relating to such a replacement, including the need for the insurer to ask if a policy is a replacement policy and requiring the insurers to provide a notice to the individual advising that such a replacement may not be in the individual's best interest. In addition, if a replacement occurs the agent's compensation will generally be limited.

COMPLIANCE BY INSURERS WITH NEW MEDICARE SUPPLEMENT REGULATION

In response to the federal law and the State Insurance Department regulations relating to Medicare supplement policies, insurers expended considerable effort to meet the very tight time schedules for providing appropriate notice to existing policyholders and preparing and reprinting new Medicare supplement contracts or policy riders for 1989. The Insurance Department was also under some severe time pressures in that we were obliged to issue a minimum standards regulation on an emergency basis, respond to insurers questions and inquiries on Medicare supplement standards and be prepared to review and approve new Medicare supplement contracts, riders, notices and rates all within a period of less than 90 days.

Prior to December 20, 1988, almost all insurers writing Medicare supplement insurance in New York State submitted for approval to the Insurance Department policy riders which eliminated duplication of benefits with Medicare and in many cases the riders also provided revisions to the Medicare supplement policies which resulted in compliance with our new minimum standards.

It now appears that fifteen insurers, including eleven commercial insurance companies and four not-for-profit corporations will be offering Medicare supplement policies in 1989 which meet our minimum standards. In addition, it appears that two health maintenance organizations will provide Medicare supplement coverage and other HMO's will offer Medicare risk contracts.

Revisions to the premium rates filed by insurers for the amended policies vary substantially depending upon a number of factors including:

-- Whether additional benefits have been added to the Medicare supplement policy.
-- The increase in health care costs in the geographic area.
-- The increase in utilization of services by the Medicare population.
-- The time period since the insurer's last premium revision.

In some cases insurers reduced the premiums modestly, others continued the existing premium rate into 1989, and most insurers required some increase in premium rate to reflect the premium rate factors mentioned earlier. However, since 1981 this Department has required insurers selling insurance to senior citizens in New York State not only to annually report the experience on such policy forms but to adjust premiums if the loss ratio standard will not be met over the lifetime of the form.

Our amended regulation requires that appropriate premium adjustments are necessary to produce an expected loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the insurers. In general, it should be noted that with regard to the Medicare supplement premium rates of Blue Cross/Blue Shield plans, the Insurance Department has for many years required that the premium rate for such coverage be subsidized to some extent by the other lines of business of the plan. The Insurance Department will have our actuaries carefully review the premium rate applications for these new contracts to assure that the premium rates approved are reasonable in relation to the benefits provided. The ongoing monitoring of the emerging experience on these forms will assure that the minimum loss ratio standards will be met.

CONCLUSION

In conclusion, the Insurance Department believes that by requiring insurers to meet certain minimum benefit standards for Medicare supplement policies, subjecting such policies and rates to Insurance Department approval, by monitoring the experience data annually and requiring appropriate rate action to assure minimum loss ratio standards are met, by monitoring the advertisement of such policies, by providing the elderly and their advisors with consumer information by booklets and oral presentations and by having the Insurance Department Consumer Services Bureau available to assist if a complaint or injustice arises, we have made a priority effort to assure that senior citizens in New York will be able to obtain and maintain significant Medigap coverage at reasonable rates.

Mr. WYDEN. Thank you very much, Mr. Corcoran. We will have some questions in one moment.

Mr. Hildreth, we will hear from you now.

TESTIMONY OF JOHN L. HILDRETH

Mr. HILDRETH. Thank you, Mr. Chairman. My name is John Hildreth, Director for the Southwest Regional Office of Consumers Union. This is a particularly timely topic for those of us in Texas because of the numerous problems besetting the insurance industry in our State and insurance regulation.

In Texas, legislation has passed the Senate as of last Friday and is pending in the House that addresses many of the abuses occurring both in Texas and across the Nation. I want to share with the committee the nature and magnitude of the problems in Texas, how regulators have failed to protect the elderly and why Consumers Union believes aggressive steps are needed now to correct those abuses.

The importance of the Medigap market is not in question. In Texas, there are an estimated 1.7 million people eligible for Medicare and, therefore, potential buyers of Medigap insurance. In 1987, elderly Texans paid more than $200 million for Medigap policies. In addition, there are more than 120,000 agents who can sell almost 600 different approved Medigap policies in the State.

Present regulation of the Medigap market in Texas is a failure. Although the State Board of Insurance continues to be aware of problems in the Medigap market, it has yet to take decisive action to correct them. Consumers Union is supporting legislation which would give Texas insurance regulators a mandate to end the abuses in the Medigap industry.

The size of the market and the ineffectiveness of insurance regulation has lead to numerous problems for elderly consumers in Texas. First, there is widespread misunderstanding about Medigap policy provisions. Second, many elderly consumers rely on the advice of insurance agents who intentionally or otherwise mislead elderly consumers in their purchase of Medigap policies. Third, many elderly send their names to lead developers for information about Medicare who, in turn, sell their names to Medigap agents. The policies sold finally are not a fair value, because Texas and most other States do not enforce the minimum loss ratio targets enacted by the Baucus Amendment almost 10 years ago.

In Texas, because the premium rates of Medigap insurance are not regulated by the State Board of Insurance, the only way consumers are assured that Medigap policies are a fair value is their reliance on the enforcement of loss ratio regulations. Loss ratios regulate the proportion of total premiums taken in by a policy that are paid out as benefits to a policyholders. In general, they measure the value of a Medigap policy.

According to the 1986 and 1987 reports issued by the State Board, well over one-half of the Medigap policies issued in Texas failed to meet the minimum State targets. While Texas adopted the Baucus standards for minimum loss ratio targets nearly 10 years ago, the Board claimed a lack of legislative authority to roll back rates. Effectively, the Board was hoping the industry would volun-

tarily comply with the minimum standards. Unfortunately, the industry has not.

Sharp sales and advertising practices dominate the marketing of Medigap policies. Texas has the regrettable reputation of being home to many of the Nation's lead developers. Lead developers generate leads or contact lists used by insurance agents to sell policies to clients.

Generally, Medigap lead developers put out advertisements which offer information about Medicare. These ads may appear to be from the government or a consumer organization, or may have an official sounding return address in Washington, D.C. Often, however, the D. C. address is only a drop box for a lead developer in Dallas.

Texas regulators have been slow to act to end these and other deceptive practices in Medigap advertising. Consumer Union's Southwest Regional Office collected numerous Medigap ads from newspapers and mailings. These advertisements are a testament to the flood of promotional materials sent to seniors. The ads also show the scare tactics employed to increase sales of Medigap policies.

I would call the committee's attention to an attachment to our statement, which has copies of some of these advertisements.

Although the Board was aware of these misleading ads, they claimed that they could do little to stop them. Years of inaction by the Board gave unscrupulous advertisers and lead developers the impression that insurance regulators in Texas could not or would not act to stop deceptive advertisements. As a consequence, Medigap advertising and the lead developer industry expanded in Texas. Because Texas is home to many of these companies and does little to stop the unscrupulous ones, other States across the Nation are adversely affected.

The bill before the Texas Legislature would require preapproval of Medigap advertisements and would require the Medigap ads to give the name of a licensed insurance agent or company. The legislation would allow the Board to prosecute those companies sponsoring deceptive advertisements.

Many of the problems associated with the Medigap market occur because of agent misrepresentations and abusive sales practices. Currently, agent licensing and educational requirements are quite lax. The State Board has begun to change the procedures for testing agents. Additionally, the bill before the Texas Legislature would require agent education in Medigap insurance as well as education about agents' duties to consumers.

However, the underlying problem of aggressive sales practices is the agent commission structure itself. Medigap agents receive much higher commissions for new sales than for renewals. Therefore, agents have an incentive to encourage the elderly to switch or twist old policies for new ones. The agent receives a higher commission and the consumer is subject to a waiting period of up to 6 months.

In order to protect the elderly from these practices, the proposed bill would credit a consumer for any previously satisfied waiting period. Further, the bill, to a limited degree, would require level commissions for Medigap agents.

Fundamental to all problems in the Medigap market is the widespread lack of understanding of Medigap policies. In order for a free market to operate correctly, consumers must make informed decisions. However, Medigap consumers are not informed consumers. There are about 600 different Medigap policies approved for sale in Texas. The policies vary from one another in so many ways, it is virtually impossible to compare the value offered by various policies.

Sadly companies succeed in Texas, not through selling fair priced and well serviced policies, but through aggressive and misleading advertising and sales practices.

The Bill pending in Texas would require the implementation of standardized policies with three different levels of coverage. Standardized policies are promulgated by insurance regulators. They specify a limited number of policy forms to reduce consumer confusion. No insurer selling a Medigap policy may sell one that differs from one of the standard forms.

Standardization permits consumers to compare policies side-by-side, since the policy offered by one insurer is identical to the policy offered by another. Standardization is the only way to assure that elderly consumers are able to make informed choices about Medigap policy purchases and who are not at the mercy of the agent selling the policy.

The West Coast office of Consumers Union is also supporting legislation establishing standardized policies in California. They plan to petition the California Insurance Department to implement the policies according to the legislation.

The growing impression of consumers is that the primary function of insurance regulation is to protect the insurance industry. The Medigap legislation that we support implements a regulatory framework placing insurance consumers first. However, consumers in Texas like consumers throughout the country, need Congress to take steps to improve the performance of this market.

Thank you for the opportunity to testify.

Mr. WYDEN. Thank you very much, Mr. Hildreth. Dr. Firman. We will put the materials into the record, in their entirety. We appreciate your summarizing your views.

TESTIMONY OF JAMES P. FIRMAN

Mr. FIRMAN. Thank you. It is very clear to us that more than 10 years after the passage of the Baucus Amendment, the Medigap industry is still fraught with major problems. The problems of substandard loss ratios continue to persist despite all the effort to regulate them in the many, many hearings that we have had in this area.

The reports of up to $40 billion in inappropriate billing of the Medicare trust fund by supplemental insurers who are carving people who are employed is another example of the system in failure. While I won't spend time in these areas, other than to say that they are obviously areas of great concern.

I would like to limit my remarks to the three problem areas of continuing evidence of duplicative and wasted coverage, continuing sale of hospital indemnity insurance to older people despite the

passage of catastrophic legislation, and the continuing difficulties that older persons face in making informed choices.

Speaking as the President of the United Senior Health Cooperative, we are an information cooperative serving 10,000 older people in the Greater Washington area. We provide consumer information, research, publication, computer analysis, and one-on-one assistance to help people make informed choices and to get through the health care maize. We operate a health care help line which provides direct, one-on-one assistance to our 10,000 members, and that is the primary basis of the experiences that I am about to report.

There are several problems that are still clearly here: duplicate coverage is not going away. Each week we encounter several cases of individuals who are obviously over insured. The first general category is the type of people we have heard about, people who have four or five or six policies, often are on lower fixed incomes and have bought through the mail or as a result of high pressure, face-to-face sales tactics.

However, there is a larger and more prevalent group which somehow seems to escape notice. These are people who already have one good Medigap policy often through their employer, and who then buy another policy which is often a group plan sold by a non-profit organization. For example, our records show that the single most common form of this type of duplicative coverage is older persons who have a Blue Cross/Blue Shield plan through their employer and then buy an AARP plan.

Both plans are good by themselves, but in combination they don't provide any significant extra value to the consumer. The Baucus Amendment in its present form, does almost nothing to prevent this form of duplicative coverage.

Another problem with the Baucus Amendment is that it has this huge loophole that enables companies to sell duplicative coverage with impunity. The intent of Baucus is clearly to prevent the sale of duplicate coverage to older persons. However, it is the pervasive industry-wide tactic to avoid this requirement by simply not asking people about their current coverage. By not asking, a company or agent is presumably not liable for selling a second or third policy.

This tactic of don't ask, don't know, not responsible is employed by virtually all of the major companies as well as the smaller ones. This is a huge loophole that is probably responsible for more duplicative coverage than all of the unscrupulous agents put together. Also, it obviously makes it easy for insurance companies to bill Medicare as the primary carrier if they can claim not to know that the person has a plan through their employer.

The third problem that we are very concerned about is that hospital indemnity plans are still being sold to Medicare beneficiaries in Medigap policies. Simply put, hospital indemnity plans are not really medical insurance, just a bad gamble for older people. As the GAO has reported, hospital indemnity plans have always been a bad deal for seniors.

Now with the improved hospital coverage under Medicare, hospital indemnity plans do not cover any significant risks faced by most older person except, perhaps, for telephone charges or television rental fees or for ordering flowers and magazine. There prob-

ably is not an reputable insurance expert alive that will tell you that it makes sense for an older person with a Medicare and Medigap policy to purchase hospital indemnity insurance.

Shockingly, we have just completed an analysis that shows that many major insurance companies continue to sell hospital indemnity insurance to older persons with Medicare and Medigap policies. We had an older woman who was a volunteer go undercover and call 20 companies. In each case she told the agent that she already had Medicare, had a Medigap policy, and asked if they thought she needed an indemnity plan.

The findings of the survey are submitted for the record. The good news is that four companies reported that they no longer sell hospital indemnity insurance. Three others said they do not sell them to people over 65. Four others said that they sell it, but with a warning that it may not be necessary.

The bad news is that nine of 20 companies surveyed, including some of the largest in the industry, continue to sell hospital indemnity insurance to people over the age of 65 even those who already have Medigap plans. No where in the marketing literature for these nine plans do they indicate that indemnity coverage is not covering any significant risk and is probably not needed. This practice is indefensible and is contrary to the best interest of consumers. We urge these companies to stop selling this dubious coverage.

The fourth concern that we have is that group policies are contributing substantially to the problems of duplicative coverage. I believe the rationale for exempting group policies from Baucus is weakening. It is no longer safe to presume that group plans are automatically more benevolent or a better deal. Nonprofit organizations that endorse or market insurance plans have an extra responsibility to protect their members against duplicative coverage, and I don't think that they are doing all that they should be in this area.

As many of the panelists have reported, it is extremely difficult for older people to make informed choices about supplemental health insurance. There can be 100, 200, 300 options out there and I think it's ridiculous to assume that any individual is going to be able to assess those and figure out which one is the best one.

Guidebooks are simply not enough. They are overwhelming, they are confusing, they go out of date virtually as soon as they are printed. As a result of this, you have the testimony of all the other panelists of the problems that persist.

It seems to me that there are two major areas of implications of our finding. It is clear that 10 years of substandard loss ratios potentially use losses to Medicare trust fund from inappropriate billing and persistent problems of duplicate coverage are compelling evidence of the limitations and failures of current regulatory approaches. We do not have an efficient and effective market for supplemental health insurance—remarks of the HIAA to the contrary.

Tinkering with Baucus can lead to marginal improvements but it will not solve the problems of a fundamentally large framework. I think this is despite what I consider to be an extremely conscientious and sometimes heroic effort by Mr. Pomeroy and his colleagues of the State Insurance Commission, who simply don't have the tools to fight the battle.

The history of the Medigap industry over the past 10 years has particularly frightening implications for the long term care insurance industry. If State insurance commissions can't effectively regulate loss ratios for Medigap and hospital indemnity insurance, it is a grand illusion to think that they will be able to regulate loss ratios for long term care insurance where the experience of plans will not be known for 30 or 40 years. As confusing as Medigap plans are to read and understand, long term care plans are much more difficult to understand.

I have five recommendations. First of all Baucus should be strengthened to require that agents and companies ask the person about their current coverage, and to inform them if they are going to sell them duplicate coverage. This would close a huge loophole.

Second, the sale of hospital indemnity plans to older people with Medicare policies should be banned flat out. Third, Congress should strongly consider regulating group policies under the Baucus Amendment or, at minimum, send them a strong warning that if they don't exercise extreme caution and to ensure that they are not selling duplicate coverage, they will be subject to regulation.

Fourth, I think we all have to realize that better regulations alone cannot solve the problems. If we are going to rely on a private market to fill the gaps of Medicare, we need to find ways to ensure that it is possible for consumers to make informed choices. The Baucus Amendment should empower States to levy a 1 percent assessment on insurance premiums to pay for State administered consumer information counseling efforts which would do much to combat this serious problem.

Thank you.

[The prepared statement of Mr. Firman follows:]

Statement of Dr. James P. Firman

President of United Seniors Health Cooperative

United Seniors Health Cooperative (USHC) is a non-profit information cooperative representing 10,000 older members in Washington D.C., Virginia and Maryland. Our mission is to enable older persons to remain healthy, independent and financially secure. We provide consumer information, publications, and research to help older persons make informed choices about their health care and health financing options. We do not sell insurance and are not affiliated with any insurance companies.

USHC currently operates a Health Insurance Help Line as a free service for our 10,000 local older members. This enables us to come face-to-face with several problems involved in the sale of supplemental health insurance to Medicare beneficiaries.

I wish I had better news to report. Unfortunately, more than ten years after passage of the Baucus Amendment, it is clear that the Medigap industry is still fraught with major problems.

Recently, the General Accounting Office reported on the continuing problem of sub-standard loss ratios for Medigap and hospital indemnity plans. News of the federal investigation of up to forty billion dollars in inappropriate charges to Medicare is another example of systemic abuse. While I deplore these practices, I will limit my testimony to our areas of direct experience.

In the process of counseling our older members and conducting related research, United Seniors has encountered several major problem areas that have eluded the Baucus amendment and other current efforts to regulate the sale of supplemental health insurance to older persons. In particular, five problem areas stand out at this time:

1. The problems of duplicative and wasted coverage are not going away.

Each week we encounter several cases of individuals who are obviously over-insured. In general, there seem to be two categories of victims. The first category consists of individuals or couples who have four, five or more policies. These people often have low or fixed incomes and have bought policies both through the mail and as a result of high-pressure face-to-face sales tactics. Despite persistence and prevalence of this problem, we know of no cases where an insurance agent or insurance company has been successfully convicted for selling duplicative or wasted coverage. So much for the effectiveness of current law and regulations.

The second and much larger group of persons with duplicative coverage are people who already who have one good Medigap policy (often through their employer) and who then buy another policy, which is often a group plan sold by a non-profit organization. For example, our records show that the single most common form of this type of duplicative coverage is older persons who have Blue Cross/Blue Shield through their employer and then buy an AARP plan. Both plans are good by themselves, but in combination they don't provide any extra coverage that is of significant value to consumers. The Baucus Amendment in its present form does almost nothing to prevent this type of duplicative coverage.

2. The Baucus Amendment has a huge loophole that enable companies to sell duplicative coverage with impunity.

The intent of the Baucus amendment is prevent insurance companies from knowingly selling duplicate or wasted coverage to older persons. However it is the pervasive industry-wide tactic to avoid this requirement by simply not asking people about their current coverage. By not asking, a company is presumably not liable for selling a second or third policy to an older person. This tactic of "don't ask, don't know, not responsible" is employed by virtually all of the major companies as well as the smaller ones. This huge loophole is probably responsible for more duplicate coverage than all of the unscrupulous agents. It also makes it easy to for insurance companies to bill Medicare as the primary carrier even if the older person is also employed.

3. Hospital indemnity plans are still being sold to Medicare beneficiaries with Medigap policies.

Simply put, hospital indemnity plans are not really medical insurance, just a bad gamble for older persons. As the GAO has reported, hospital indemnity plans have always been a bad deal for older persons. Now, with the improved hospital coverage under Medicare, hospital indemnity plans do not cover any significant risk faced by most older persons. There probably isn't a reputable insurance expert alive who will tell you that it makes sense for an older persons with Medicare and a Medigap plan to purchase hospital indemnity insurance.

Shockingly, we have just completed an analysis that shows that many major insurance companies continue to sell hospital

indemnity insurance to older persons with Medicare and Medigap coverage. During the past month, an older woman who is a volunteer at United Seniors Health Cooperative telephoned the twenty insurance companies that sold the most hospital indemnity insurance in 1987. In each case, she told the agents that she already had Medicare and a Medigap policy and asked if they thought she needed a hospital indemnity plan. The findings of this survey are submitted for the record. The good news is that four companies reported that they no longer sell hospital indemnity insurance, three others said they do not sell them to people over the age of 65, and four others sell it with a warning that the policy may not be necessary.

The bad news is that nine of twenty companies surveyed, including some of the largest in the industry, are still aggressively marketing hospital indemnity policies to people over the age of sixty five, even those who already have Medigap plans. Nowhere in the marketing literature for these nine plans do they indicate that the hospital indemnity coverage is not covering any significant risk and is probably not needed. This practice is indefensible and contrary to the best interests of consumers. We urge these companies to stop selling this dubious coverage to older persons.

4. Group policies are contributing substantially to the problems of duplicative and wasted coverage.

The rationale for exempting group policies from the Baucus amendment are weakening. It is no longer safe to presume that group plans are automatically more benevolent or better deals for consumers. Non-profit organizations that endorse or market group

insurance plans should have a particular responsibility to protect their members against duplicate or wasted coverage. Group policies contribute significantly to the problem of duplicate coverage. Some of the group plans are still marketing hospital indemnity insurance plans to older persons without indicating that it probably not a good idea.

5. Most older Americans find it very difficult to make informed choices about supplemental health insurance.

Unfortunately, it is very difficult for most older consumers to make informed choices about competing plans. The language in most insurance policies and their marketing literature is often very difficult to understand. Each company provides the information in a different format, and (to the extent possible) accentuating the benefits and minimizing the limitations of their plan. Guidebooks published by state agencies are simply not enough: they are often overwhelming, confusing and go out-of-date very quickly. As a result, many people don't have a good place to turn and buy policies without really understanding their coverage.

Implications

Ten years of sub-standard loss ratios, potentially huge losses to the Medicare trust fund from inappropriate billing, and persistent problems of duplicative and wasted coverage are all evidence that current regulatory approaches have not led to an efficient and effective market for supplemental health insurance to Medicare. Tinkering with Baucus can lead to marginal improvements, but it will not solve the problems of a

fundamentally flawed framework.

The history of the Medigap industry over the past ten years has particularly frightening implications for the emerging long-term care insurance industry. If state insurance commissions can't effectively regulate loss ratios for Medigap and hospital indemnity insurance, it is folly to think they will be able to regulate loss ratios for long-term care insurance where the experience of plans will not be known for as long as thirty or forty years. As confusing as the Medigap market is for older consumers, it is much more difficult for consumers to make informed comparisons among long-term care plans where there is considerably less standardization of benefits, restrictions and use of terms.

Recommendations

1. The Baucus amendment should be strengthened to require agents and companies to ask a person about their current coverage and to inform them if purchase of their plan will result in duplicate or wasted coverage. This would go a long way toward closing what is a huge loophole in efforts to prevent the sale of duplicative and wasted coverage.

2. The sale of indemnity hospital plans to older people with Medigap policies should be banned. A weaker fall-back position would be to require that the marketing literature for hospital indemnity plans include a warning label that such plans are of limited value and probably not needed by people with Medicare and Medigap policies.

3. Congress should consider regulating group polices under the Baucus Amendment. At a minimum, a stern warning should be issued to providers of group insurance plans and non-profit organizations that endorse them that if they don't clean up their acts they will be subjected to the same regulations as individual policies.

4. Better regulations alone cannot solve the problems of duplicative and wasted coverage. If we are going to continue to rely on the private market to fill gaps in Medicare, we need to find ways for ensure that it is possible for consumers to make informed choices. The Baucus amendment should be revised to empower states to levy a 1% assessment of insurance premiums to pay for state-administered consumer information and counseling efforts which could do much to combat this serious national problem.

In summary, millions of older persons are still the victims of of sub-standard loss ratios, duplicative and wasted coverage, and the difficulties of making informed choices in a complex and confusing market for supplemental health insurance. If Congress does not want to solve these problems directly by extending Medicare, it should take the decisive actions necessary to ensure that it most, if not all, older persons are able to make informed choices among good plans.

To: Congressman John Dingell, Chairman Subcommittee on Oversight and Investigation

From: James Firman and TG Gifford, United Seniors Health Cooperative

Subject: Companies still selling Hospital Indemnity Policies to individuals over age 65 as of April, 1989

As a result of the new changes in Medicare, hospital indemnity insurance is a poor form of extra financial protection for most older persons. However, many companies continue to sell it to Medicare beneficiaries, even those with Medigap policies.

Companies still selling Hospital Indemnity Plans:

Colonial Life and Accident Insurance Company *
Commercial Travelers Mutual
National Home Life Assurance *
Pennsylvania Life Insurance Company *
Physicians Mutual *
Prudential **
Teachers Protective Mutual
Union Fidelity Life
United American

Companies still selling Hospital Indemnity Plans, but with a warning that the policy may not be necessary:

Bankers Life and Casualty *
Mutual of Omaha *
Reserve Life
The Hartford **

Companies that are selling Hospital Indemnity Policies, but that to not sell to individuals over age 65:

Monarch Life
State Farm *
Washington National

Companies that said they are no longer selling Hospital Indemnity Insurance:

American Heritage Life
Colonial Life
Gulf Life
Montgomery Ward Life

* These seven companies accounted for 77% of total individual hospital indemnity earned premiums for the years 1982-1986 according to the July 1988 GAO study "Hospital Indemnity and Specified Disease Policies are of Limited Value" (GAO/HRD-88-93)

** Group plans

Mr. WYDEN. Dr. Firman, thank you very much, and all of you have been helpful. Let me begin with you, if I could, Mr. Pomeroy. I want to ask you to start with the same question that I asked Ms. Burns.

That question is, despite Baucus, despite the fact that there are good companies in the field and good agents, and despite the public education that has gone on, would you agree with her conclusion, Mr. Pomeroy, that there are still a substantial number of ripoffs taking place out there as far as the elderly and Medicare supplements?

Mr. POMEROY. Mr. Chairman, I would agree there are a number of consumer fraud abuses in the Medigap market.

Mr. WYDEN. Do you think it is a significant number though? The reason that this is so important to me is that there already is a debate about whether this isn't a big deal or whether it is still a significant problem. What our previous panel basically told us is that it is still a significant problem. We acknowledge that there are good companies out there. We acknowledge that Baucus has helped and acknowledge public education.

Do you think that there are a substantial number of serious ripoffs taking place?

Mr. POMEROY. Mr. Chairman, I am not trying to dodge your answer. I think that the anecdotes in and of themselves, if they don't represent a large class of similar situated incident, would constitute a substantial problem. Based on numbers reported to insurance commissioners, it appears that of all complaints received, it falls in the 10 percent range. Those are the ones that we learn about. Certainly, there are others that we don't learn about.

I believe that given the complexity of the Medicare program, there will always be a good deal of confusion in the Medicare supplement insurance program. I also believe the elderly, representing a frail and susceptible population, will always be targeted by con artists including insurance sales persons.

So, I think this will always be an area that requires close regulatory scrutiny. I think the market has gotten better. I don't think it is as bad as it was, but I do take the position that more needs to be done.

Mr. WYDEN. That is helpful. My second question, again along the lines of what I asked Ms. Burns is, do you see the same problems starting to develop with the long term care policies as we have seen with the Medigap supplements. It seems to me that the long term care policies, if anything, are more complicated. The loss ratio data may be vastly harder to follow.

Do you see the same problems developing with private, long term care insurance that we sell with Medicare supplements?

Mr. POMEROY. Mr. Chairman, the long term care insurance marketplace is very new. This has been an area where regulators move quickly to put in place meaningful, minimum standards so that the products on the marketplace were not illusionary, were high quality products. We have, as the market has developed quickly over the last 2 or 3 years, brought our standards along and strengthened them significantly.

It is such a new marketplace that I cannot tell you we have seen a good deal of the identical type of abuses occurring. There are a

number of similarities in the markets, however, that lead me to believe that it is an area also that we have to be terribly concerned about as regulators.

Mr. WYDEN. Would you agree with my assertion though that, if anything, this is a much more complicated market for seniors to understand?

Mr. POMEROY. It is a very complicated market. Potentially, it is even more complicated than Medicare supplements.

Mr. WYDEN. With respect to the point on the Baucus issue, Ms. Burns and others have been particularly concerned about what they see as a loophole with respect to duplication.

Is the NAIC prepared to support new initiatives to try to deal with the duplication issue which, I think is particularly important, given the fact that we have tried in the catastrophic bill to address the duplication issue. But it is clear from what Ms. Burns and the other witnesses said, that won't completely do it.

Will the NAIC support new initiatives to try to deal with the duplication issue?

Mr. POMEROY. Yes we will, Mr. Chairman. The State of Minnesota and North Dakota, for example, have taken an approach based on a suitability regulation, placing upon the agent an administrative requirement that the policies sold be suitable for the insurance needs of the consumer. This avoids some of the technical difficulties in bringing the prosecution under the Baucus duplication language, and is much more comprehensive and effective as a regulatory tool.

That approach is now under consideration by the NAIC for adoption as a model. We are looking at that area.

Mr. WYDEN. So, you would anticipate whether it's the Minnesota approach or that of something else that NAIC devises, you would anticipate having out a model approach for the States to deal with this duplication issue within 6 months, a year?

Mr. POMEROY. By the end of the year, Mr. Chairman.

Mr. WYDEN. By the end of the year. Let me ask you a couple of more questions, because I know that my colleague from Ohio has a longstanding interest in this as well. A number of our witnesses have talked about the standardization issue.

Is the NAIC looking at initiatives to try to deal with this as well? I have been interested in this for a number of years and recognize that it is a very complicated issue. But it would seem to me that given the complexity of the subject, given the fact that it is going to become more complex as we get into the long term area, that this would be a worthwhile avenue for consideration.

Does NAIC anticipate looking at standardization issues?

Mr. POMEROY. To an extent, Mr. Chairman. In the long term care area first, we have put in place very tough minimum standards that prohibit for example when adopted and after a transition period, the 3 day prior hospitalization period distinguishing between levels of care in a nursing home, pitfalls in coverages that are very difficult for the consumer to understand. That isn't standardization because we allow policies to vary once they have met the minimum standard.

By putting in place a tough minimum standard, we have taken a giant step toward the goal that those advocating standardization

would seek. In the Medicare supplement market, I have closely looked at the neighboring State of Minnesota which has gone to a four alternative approach by way of standardization, and was not convinced at the time we reviewed their marketplace and ours that it eliminated the problems that we were concerned about.

We will continue to study any means of making further inroads about the abuses that are continuing in this market. At least for purposes of this morning, I am not as convinced as some of the proponents of standardization who have testified this morning, that that solves as many problems as they believe.

Mr. WYDEN. Are there other avenues, Mr. Pomeroy, that could be pursued to try to simplify and make more coherent these policies to people? Perhaps there is something other than standardization. That's one thing our witnesses have consistently talked about. Are there other avenues to try to make these policies more understandable?

Mr. POMEROY. Mr. Chairman, none that are immediately apparent to me. We have a marketplace of individuals who have not been in the habit of shopping for individual health coverage. The highest percentage would have had coverage at their place of employment. They retire and are forced into shopping for two very difficult types of coverages to buy long term care coverage and Medicare supplement coverage.

Medicare supplement coverage, which dovetails around the Medicare program which is subject to periodic changes from time to time and covers some things and doesn't cover other things, your difficulty is endemic in the product. I don't think there is a quick and simple way to suddenly make all those complexities go away.

Mr. WYDEN. But you wouldn't say that this is something to just let market forces try to deal with. This is a unique market where you have vulnerable people in a complicated subject, wouldn't you agree?

Mr. POMEROY. I agree absolutely. It is the highest regulatory priority.

Mr. WYDEN. Let me ask you one other question. With respect to this post-catastrophic climate, I think that Dr. Firman has made a very important point with respect to one area that would really be ripe for exploitation, and that's this question of hospital indemnity policies because the catastrophic bill tries to deal with much of that area.

Does the NAIA intend to pursue initiatives to deal with this area?

Mr. POMEROY. Mr. Chairman, we do not have a pending initiative to prohibit, as Dr. Furman suggests, the sale of hospital indemnity products to senior citizens. Frankly, I think it is worth taking a look at.

Mr. WYDEN. You would share my view though that a person who wanted to try to exploit an older person post-enactment of the catastrophic bill, the hospital indemnity area would be a pretty good one to try to hustle?

Mr. POMEROY. It would, Mr. Chairman. It would be illegal in North Dakota and Minnesota under that suitability regulation which we will be advocating be adopted as a model. I think that's one way we can address that.

Mr. WYDEN. It would not be illegal in most States in the country today, post-catastrophic, to go on out there and aggressively try to market those hospital indemnity policies; would it not?

Mr. POMEROY. In a number of jurisdictions it is not clearly prohibited. In as many as potentially 15 to 20, however, there is some appropriate regulatory prohibition.

Mr. WYDEN. The gentleman from Ohio, Mr. Eckart.

Mr. ECKART. Mr. Hildreth, do I understand in your testimony that even though Texas has been certified as meeting the formal requirements for Federal law, most companies are not meeting the legal loss ratio?

Mr. HILDRETH. That is right.

Mr. ECKART. Do they hold hearings on rate increases in Texas?

Mr. HILDRETH. No.

Mr. ECKART. Have any rates ever been rolled back in Texas?

Mr. HILDRETH. No.

Mr. ECKART. Essentially, the loss rate requirements are just being ignored?

Mr. HILDRETH. That's correct. They have released reports, loss ratio reports for 1986 and 1987, and those have indicated that as many as half of the policies have failed to meet those targets. There is no effort on the part of the State Board of Insurance to do anything about that. That is a part of the legislation that we are trying to get through the Texas Legislature now which would allow the State board to roll back rates or declare a dividend.

Mr. ECKART. The NAIC is now telling us that things are changing this year, that their model will now require that actual losses be submitted and met. Do you expect that will be the case in your State?

Mr. HILDRETH. I am encouraged that NAIC may have a model. Unfortunately, they don't pass laws in the State of Texas, nor does it serve as a mandate for the State Board of Insurance. Our track record in our State is that the State Board has failed to take the initiative. We believe that they have the authority now to do something in this area, but have just failed to do so.

Mr. ECKART. Shouldn't a company be forced to make a fair payout each and every single year?

Mr. HILDRETH. We think so. We wanted to do that on an annual basis in the legislation that we have pending. We have had to compromise in that area. There is a 10 year period over which——

Mr. ECKART. Wait a minute. Ten?

Mr. HILDRETH. Yes.

Mr. ECKART. As in this many?

Mr. HILDRETH. Both hands.

Mr. ECKART. Why 10 years?

Mr. HILDRETH. Because it was necessary to compromise in this particular area to get the bill out of the Senate. They are required, on an aggregate basis, to look at those loss ratios to improve each year over a 10 year period in order to meet those targets. We would hope for something stronger, but that's not what we were left with.

Mr. ECKART. It is an awful long time. Some of the folks you are working real hard to try to protect here may not be around at the end of those 10 years.

Mr. HILDRETH. That's true. I wish we were in a better position. I don't think that we are going to be with this particular bill.

Mr. ECKART. I wish you were in a better position too, and I appreciate your testimony and comments. Commissioner Pomeroy, one of my big concerns obviously, is low loss ratios. A GAO report shows that a majority of commercial sellers of Medigap policies continue to return less than 60 cents on the dollar.

Is the new requirement that policies meet actual loss ratios guaranteed really to change that?

Mr. POMEROY. Congressman Eckart, that is correct. Baucus initially required expected loss ratios. A number of States had gone to an actual loss ratio requirement prior to the passage of the catastrophic care amendments. The effect of passage of that act will bring in place an actual loss ratio requirement in all States that ultimately obtain certification. We expect that all States, including Texas, will. I believe that this will be a addressed in Texas as well under the catastrophic.

Let's discuss for a moment, a point of frustration that I have with loss ratios as a meaningful regulatory tool. The problem with using loss ratios—loss ratios is almost a deceptively simple concept. In reality however, the fact of the matter is that it is tough for a regulator to use. There are valid actuarial considerations that must be taken into account in attempting to determine the loss ratio on a book of business.

The loss claims experience on a policy will increase the longer that policy is in the hands of the insured. In other words, a policyholder that has held a policy for 6 months probably will not have incurred a medical claim. Someone that has held it 3 years most certainly would have probably incurred some.

The older the book of business, the higher the loss ratios will be. The difficulty oftentimes with low loss ratios is that it can be demonstrated that a disproportionate percentage of that book is relatively new business and will not yet have hit——

Mr. ECKART. Don't losses also include reserves for future liabilities?

Mr. POMEROY. In North Dakota's efforts to bring actions against companies not hitting target loss ratios, we have not found the reserves to bring up the low loss ratio experience on new books of business to be an effective way of using loss ratios.

Mr. ECKART. So you don't calculate in, in your set of circumstances, reserves in a future contingent liability?

Mr. POMEROY. Congressman, we are on the edge of my technical expertise. The reporting form does not include loss reserves for purposes of assessing what the loss ratio on a book of business is. I have to correct that answer. It is taken into consideration on the report form.

Nonetheless, reserving requirements added to low payouts do not completely eliminate the difficulty of prosecuting low loss ratios.

Mr. ECKART. I can see that it may be difficult to devise a precise number, and that there may be some vagaries in the calculation of that number. But at the GAO has reported to us, when we start seeing some policies down here at 12 percent and 14 percent and 34 percent contrasting with policies in the 80's, 90's and high 70's, there is significant difference in policies.

Is there a difference between a 42 and 46—probably not. A 40 and a 50, I suspect, given the differences. Having been the Chairman of the Insurance Committee in the State Legislature in Ohio, I understand how they can change from State to State. There is a big fundamental difference between 14, 40 and a 40 and an 80.

You are not trying to assert that the characterization of loss ratios is a meaningless statistic for measurement in this policy?

Mr. POMEROY. Congressman, I am not trying to assert that. I am as suspect of a low reported loss ratio as you are, members of the public, might be. I have attempted and have directed staff to review and establish administrative actions so that we can proceed for the purpose of obtaining premium reimbursement against those companies, and have been unsuccessful in getting a case that we could prove up in an administrative hearing level in light of the actuarial justifications offered by the companies inevitably relating to the maturity of the book of business.

Mr. ECKART. Mr. Corcoran, do you want to be heard on that?

Mr. CORCORAN. Yes. As Commissioner Pomeroy has pointed out, there are a lot a difficulties when you calculate loss ratios. You have go give these products time to mature. We found it to be a very effective tool.

I would like to point out that the 65 percent criteria in New York has been relatively successful. We have companies who have not met that requirement. We find that and make them either increase benefits or reduce premiums in the future. The vast majority of the people in my State are covered by Blue Cross/Blue Shield, which loss ratios are 100 percent. Unfortunately, their share of the market is smaller.

The 65 percent where we found in 1987—we examined some companies who did not meet that requirement. It required them to adjust their premiums and, in one case, increase their benefits. Four companies came back and reduced their premiums and two maintained their premiums at current level for future purposes with the same clientele.

It is one tool. It's not the absolute answer, but it's a good tool. It needs some time to let the products mature, and then you look at it. The other tool that I think is very important is the disclosure requirement. I was surprised to hear that there were 600 Medicare supplements in Texas. My booklet from 1988 says that we have 38 approved and 38 cost comparisons. You have to take this from a multi-faceted approach.

Loss ratios are one, disclosure are the other, and the next thing is the question of standardization, which I think is a very valid discussion that we can have now. In light of the recent catastrophic bill we can bring some sanity to this. The NAIC's efforts toward that and this dialogue is very constructive.

So, it can be answered and responded by State regulation. I think we can look at some of the success stories. I think that New York is a relatively good success story. Other States are using the standardization approach.

Mr. ECKART. Are you a file and use State?

Mr. CORCORAN. No. We have prior approval for years of all the products. The duplication, we have not had a duplication problem at all, because the products have to be approved for use in the

State. The duplication question doesn't come up in New York State.

As far as the complaints that we have in New York State, there are about 700 complaints regarding the products. That's about 1 percent of the consumer complaints in my State.

Mr. ECKART. Are you a file and use State, Mr. Pomeroy?

Mr. POMEROY. Congressman, we are a prior approval State. I do have some information which I think places the loss ratio question somewhat in perspective. The NAIC obtains loss information for all of the commercial and most of the Blue Cross/Blue Shield plans in the country. That data shows on average, that individual Medicare supplement business ran 77.4 percent loss ratio in 1987 and group business ran an 88.3 percent loss ratio in 1987.

The companies reporting lower loss ratios, whether legitimately or not, represent a small portion of the marketplace. Again, to the extent that there is not substantial actuarial justification for their low loss ratios, it certainly ought to be a matter of regulatory concern and we now have an actual loss ratio reporting requirement and a filing requirement of that loss ratio information and supporting data with each State.

Mr. ECKART. Mr. Pomeroy and Mr. Corcoran, let me ask you this. If there are vagaries in the use of loss ratio as a key indicator for whether a policy is a good buy or not, what are some of the statistics that you would direct a senior citizen to use, as to whether or not a particular offering is a good purchase?

Mr. CORCORAN. I guess the basic approach we have taken in New York, which we think has been successful, is disclosure. I don't want to understate my support of loss ratios. I think that loss ratios are a very solid basis. The senior citizen, of course, does not get to see the loss ratios. They would be misleading to an extent anyway, because you might have a very comprehensive pro-consumer new product that couldn't show a loss ratio that would show projections.

So, I don't think that I would go to the public and say—if they wanted the information we would give it to them. With a booklet that compares the benefits and gives the annual rate, that's probably the best approach for the senior citizen.

The next approach as you have testified here today, and we have been concerned about, as I noted in my testimony we make the agent specifically sign a statement saying that the second product might not be necessary. There is a question of whether or not we should allow a second product. We will have a hearing in New York.

That is only new because of the recent catastrophic bill. You have simplified, to a certain extent, the regulatory need for it. I don't want to belittle my strong support for loss ratios. They are only as good as the willingness of one, the regulatory body obviously, and the State legislators are willing to finance the departments of the various States.

You need actuaries and technicians to look at these. You need examiners to go out into the field. It is a constant problem that we have as regulators. I am sure that Congress' awareness of these issues help us with our dialogue with the legislature regarding budget need protection.

You are only as good as you know here, in the Federal Government, as the ability of your regulator to do the job. When you had your problems in Wall Street, it was because of your SEC budget was totally inadequate. We always face those issues. The loss ratio is a good way of doing it, but you do need staff.

Mr. ECKART. Mr. Corcoran, will you be able to by rule, to outlaw the sale of second or subsequent policies?

Mr. CORCORAN. Yeah. We do have the authority to do it on the grounds of suitability or excess. The law in the State of New York is such that there are certain products we don't allow to sell in the State of New York based on a statute which says that the regulators found them not worth the premiums in relation to the benefit to the public as a matter of public policy and not of any value. We have excluded some products that can be sold in other States, based on that statute.

Mr. ECKART. Mr. Pomeroy?

Mr. POMEROY. The key indices that we would encourage consumers to compare would be the outline of benefits, compare head to head what the policies are containing by way of coverages, and price charged for those coverages. We would also encourage some inquiry into the claims payment reputation of that company and, finally, the company's best rating as an indicator of their solvency.

Mr. ECKART. I thank you, and I thank the chairman.

Mr. WYDEN. I thank my colleague. Mr. Pomeroy, you said NAIC is now in the process of collecting loss ratio data. Does NAIC have actuaries to review this data, or what will happen to it after it has been collected?

Mr. POMEROY. We do not have an actuary on staff, Mr. Chairman. We do have an economist. The reporting form on the loss ratio will generate the data which will ultimately then be submitted back to the States in addition to the information they already would have received from the companies in the annual statements.

Mr. CORCORAN. Congressman, I would like to stress though that NAIC Commissioners work very close together, and the results of all States are available to each other to be used. It has been that spirit of cooperation over the last 6 or 7 years that enable us to take what we feel are very long steps in solving many problems.

There is the cooperation and availability of a pool resources of 50 regulators.

Mr. WYDEN. There is no question about that. I frankly don't see where we are going to get the actuaries under the current system to really assess this data. I mean, my State and others tell me that they are very strapped for resources. I am going to ask some questions about some of the other logistical problems with respect to computers and the like.

If the States have difficulty getting actuaries, Mr. Pomeroy has told us that he doesn't have an actuary on his staff, where are we going to——

Mr. CORCORAN. Congressman, let me point out to you that the average makes more than a Federal judge. That is a universal problem for the Federal and State government. If you don't compensate civil servants to the degree for which they should be compensated in all aspects, it is something that you and I can talk about for days.

Mr. WYDEN. My question is, how are we going to do anything more with this loss ratio data other than just collect it under the present system?

Mr. CORCORAN. You don't need actuaries per se, examiners can calculate that. Actuaries are more projectual.

Mr. WYDEN. I have spent 15 years having people in this field tell me how complicated it was and how many Members of Congress and Gray Panthers and others couldn't possibly understand it. We had to, in effect, give it over the actuaries. I have given great credence to that point of view.

Mr. Pomeroy and others are now telling us that you can't afford actuaries and we don't have actuaries. I just wonder where we are going to go to get this data analyzed.

Mr. POMEROY. The loss ratio does have a value, even for a staff without an actuary, at the time that a rate filing is made. While we have had difficulty using a loss ratio as an instrument to go back in and force a rate reduction, we have found it to be very helpful by use of our non-actuarial rate analysts at a time that a filing may be made for a premium increase.

If there is not supporting justification, given their loss ratios, at that point that proposed rate increase is denied. It does serve some utility, although not the full extent one might hope.

Mr. CORCORAN. I would also point out, Congressman, under the authority of most regulators, the cost of examination is paid for by the companies. If the commissioner needed to hire outside people, actuaries or others to do the examination, they have the power to do so.

Mr. WYDEN. Why don't we do this, Mr. Pomeroy. Why don't you get us, for the record, your statement about exactly what happens to the loss ratio data that you collect. I would like to see how it is used and pursue it as a tool to try to help consumers.

Mr. Pomeroy, let me ask you and Mr. Hildreth, when NAIC puts out a model law it is not always adopted in the fashion that NAIC advances it as a model; is that correct?

Mr. POMEROY. That's correct.

Mr. WYDEN. Mr. Hildreth, you have such a situation I gather in Texas where, in effect, in Texas there have been some changes made in the model areas, the model legislative proposals that would help consumers.

Is that correct and, if so, perhaps you could describe what kind of changes were made.

Mr. HILDRETH. That is correct in the loss ratio area, where in 1981, the legislature adopted the Baucus targets. The Board, in response to petitions by our organization, has always indicated that they have no authority to enforce those loss ratios and have been slow in terms of the collection and reporting of those ratios, so that the information becomes of little value and there is never any action taken to do anything about the failure of policies to meet those targets.

Mr. WYDEN. A question for you, Mr. Pomeroy and perhaps for you, Mr. Corcoran. The GAO and FTC investigators have told us that in many instances insurance departments around the country are operating like most business did in the 1950's before the advent of the computer. That, because of limited resources as the State

level, in many instances they find it difficult to retrieve by computer statistical information on license issuance and things of this nature.

Do you believe like GAO and FTC, that this is a significant problem in terms of trying to get on top of these issues, Mr. Pomeroy?

Mr. POMEROY. Mr. Chairman, insurance regulators are faced with the prospect of regulating a vast and rapidly changing industry. To that extent, I don't suppose there is an insurance commissioner in the country that would say he has adequate resources anymore than you would say that you have adequate staff available to you as a Member of Congress.

Mr. WYDEN. These are very capable staff.

Mr. POMEROY. I didn't talk about quality, we are talking about number of staff, Mr. Chairman, which is the problem with State insurance departments. Yet, I do think those indicating regulation is where it was in the 1950's are way off the mark.

Presently, there are over 6,000 men and women employed as State regulators, insurance regulators, in the various States in the country. The combined budgets of State insurance departments exceed $300 million. The NAIC has a staff in excess of 100 and a dramatically improved capacity to assist State governments.

In addition, we have developed certain areas of expertise of NAIC staff that we did not have before, including Washington counsel and a greater depth of legal support.

Mr. CORCORAN. My own situation, I think that I would not say that we are understaffed. We have 810 people in the department and another 600 liquidation bureaus. The regulating companies are in trouble. We are a highly computerized operation, with a budget of approximately $50 million which compared favorably a couple of years ago to the SEC which had $117 million.

I think you have that disparity, but those resources Mr. Pomeroy pointed out are pooled and used as a group.

Mr. WYDEN. Mr. Pomeroy, there was a study done by a public interest group, the Consumer Insurance Interest Group. I gather that you all were consulted on and others, that found that one-fourth of all the States couldn't retrieve by computer statistical information on license issuance and only one-third of those interviewed had automation systems compatible with the model established by NAIC.

Is that your assessment of where we stand and, if so, would that kind of finding trouble you as the representative of the NAIC trying to get these regulations and rules in place?

Mr. POMEROY. Mr. Chairman, I am not prepared to accept that finding as reflective of what the computer capacity of State regulation presently is. With the new NAIC computer capability, there are terminals in each of the insurance departments and an ability to communicate one with another on a daily basis, both with NAIC staff and other States.

I am not entirely sure that is an accurate reflection of where we are today.

Mr. CORCORAN. I think it also should note that when you use figures like that, that it doesn't distinguish domestic markets from national markets. I have to be quite candid. Most big companies and most companies are licensed in New York, Illinois, California,

Florida and Texas to have substantial insurance departments that are highly modernized.

They love to have fun with some of the smaller States who, quite candidly, don't need the substantial State operation because they have only a few domestic companies. Those numbers and statistics are twisted and turned a bit for purposes of—there are times when the agent groups who want regulators to take down companies. You always have to look for everything, where it's coming from, timeframe of the cycles.

It distorts the reality. The reality is that most companies are domesticated or licensed in one of the major well staffed, well financed departments who oversee them in their operations as national.

Mr. WYDEN. Let me ask one other question of you, Mr. Pomeroy, and then I want to recognize some of your associates for questions.

What exactly is a market conduct study? I have been told that some regulators believe that this is a useful tool to deal with that small number of companies that seem to be consistently involved in questionable practices. Tell us, if you would, what it is and, if so, if this could possibly be used on a more widespread basis to deal with some of the problems that we have been hearing about today?

Mr. POMEROY. Mr. Chairman, the market conduct examination is a relatively new type of insurance examination. It is somewhat analogous to a financial examination, where examiners actually go into an insurance company and review—in the case of a financial examination—basic material relative to company solvency.

In the case of a market conduct examination, they review material relevant to payment of claims, for example, in an insurance company for purposes of trying to assess market conduct. Presently, 92 percent of States regularly perform compliance examinations; 62 percent regularly hold market conduct examinations. I believe that market conduct examinations will be a valuable part of insurance departments learning of companies that are abusing the public, hopefully at a point earlier than might otherwise become known to them through the complaint process.

North Dakota entered a market conduct examination of a Pennsylvania company called Providers Fidelity. Abuses were noted in the course of that market conduct examination which substantiated concerns that we had seen from an anecdotal complaint reporting process to the insurance department.

Based upon the market conduct information, along with the complaint information, we were able to put together an administrative action that resulted in a substantial fine and a barring of this company from the senior market for a period of 2 years in North Dakota. It has also been available and used by Plaintiff's counsel in litigation against that company.

Yes, there is an expanded role, I believe, market conduct examinations will play in this area.

Mr. WYDEN. You and the NAIC would support an expanded role for market conduct studies? That was what I asked, and that's what I think you said. I just want to make sure that is correct.

Mr. POMEROY. In answering your question, we think that market conduct will play an important part of State regulation. We would have some reticence about a Federal market conduct role.

Mr. WYDEN. Nobody is talking about that. Do you think that there should be more——

Mr. POMEROY. I'm getting paranoid.

Mr. WYDEN. I didn't mention the word. Do you think that there should be more widespread use of market conduct studies by the States?

Mr. POMEROY. I would have to say that the NAIC does not have a position that I can articulate to you. The North Dakota insurance department believes that, yes.

Mr. WYDEN. A couple of questions for you, Dr. Firman. What do you see as the post-catastrophic care legislation environment. Is there tremendous confusion right now among senior citizens groups about exactly what the legislation entails and how it relates with private insurance?

Mr. FIRMAN. There is no question about that. There is a tremendous amount of confusion. People are upset, first of all in not understanding the catastrophic legislation, and understanding that because Medicare has expanded that Medigap is less valuable.

I just can't let one comment pass which I heard. It was an impression by Mr. Corcoran, which he said that he had 810 regulators and that there was no problem of duplicative or wasted coverage in New York State. I think that's an amazing statement. I think that all surveys show that about 25 percent of all the people who have Medigap policies also have indemnity plans. That is a form of duplication.

Mr. WYDEN. I am going to continue to ask the questions.

Mr. FIRMAN. I'm sorry. I just thought that statement was——

Mr. WYDEN. I asked you a question, and I am going to let you finish the answer. When you are done, we will recognize Mr. Corcoran for any additional comments he might choose to make.

Mr. FIRMAN. I would suggest to Mr. Corcoran, we have talked to the Office of Aging in New York City, in Buffalo, and in Rochester which are three that I happen to know of which have contacted us, because they have encountered many people who get duplicate coverage.

I couldn't let that go by. I'm sorry.

Mr. WYDEN. I am going to have some additional questions for you, Dr. Firman, but I did recognize Mr. Corcoran that you wished to add a comment.

Mr. CORCORAN. It was a misunderstanding. When I talk about duplication, I mean duplications in the product itself by prior approval. No one is saying that there are not people selling double policies. That is why we specifically make them sign that statement saying that a second policy might not be good.

Don't get too excited. It was a mistake of verbiage, not the substance.

Mr. FIRMAN. I'm glad that we cleared that up.

Mr. WYDEN. Dr. Firman, I was very concerned about the comments that I heard before the hearing with respect to this lack of actuaries and examiners, particularly the implications that it would have for commissions. I just don't see how State insurance commissions can really do what needs to be done in looking at these loss ratio issues, if they just don't have the necessary technical expertise to properly evaluate data.

Now, Mr. Pomeroy and Mr. Corcoran have essentially suggested to the committee that this absence of actuaries is not as serious a problem as I and perhaps other outside experts are suggesting. Do you share that view? Is it possible to really look at these rate issues, rate request issues and loss ratio issues if there aren't actuaries and technical people who are in a position to do it?

Mr. FIRMAN. I don't think that even if there were the actuaries there—I think I heard Mr. Pomeroy say that loss ratios are really going to be an effective tool for regulating the market. At best, keep in mind, all we are talking about is regulating mediocrity.

We are talking about guaranteeing that plans pay off 60 percent which, in my view, is no great shake. It is not a goal of social policy to see that insurance plans pay off 60 percent loss ratios is not a very effective social policy.

I think that we have heard everything that they have said, that it is just not a workable tool, and I think they are right. I certainly feel that way.

Mr. WYDEN. One more question for you, Mr. Pomeroy. Do all of the States in the United States have adequate authority at this point to pursue out of State sellers who try to peddle deceptive products?

Mr. POMEROY. The catastrophic extension to Medicare and the attendant new regulations have substantially improved all of the States' position relative to products based on out of State groups. Formerly, some States such as mine, assert extra territorial jurisdiction and had that authority.

The new extension brings a filing of the product, the loss ratio, the rate, and supporting documentation of every policy including certificates sold in that State. In my opinion, this would be a substantial improvement right across the board in the ability of a State to monitor out of State groups.

Mr. WYDEN. Let me make sure that I have that. The question is, State authority with respect to deceptive out of State sellers—you are saying that the catastrophic care bill dealt with it to a substantial degree. Didn't the catastrophic care bill call on the States to take action in this regard, and what happens if the States don't take action in this regard?

Mr. POMEROY. Those requirements, which are imposed on the regulatory structure via Baucus and via the update of Baucus, will not be certified as in compliance with the standards. When you talk about out of State sales, I responded believing that you were asking me a question about a group product based in one State where certificates are sold into another State.

Mr. WYDEN. That's correct, a group product or an individual product.

Mr. POMEROY. If the question is regarding out of State insurance agents, those do business in a State via non-resident agent license. I believe a State does have sufficient regulatory authority over those it had in the past and continues to have.

Mr. WYDEN. We are concerned about the product. I understand the regulatory role over the agents. I guess what I want to know at this point, because I think you are correct that the catastrophic care bill sought to also move us forward in this area.

If States don't act on this point, would the NAIC for example, support the Federal legislation to deal with this matter?

Mr. CORCORAN. New York we passed a statute in light of this question, deeming someone who mails certificates into the State is doing business of insurance in the State. If that certificate does not meet with the minimum standards that we imply, we will deem it as having those standards. A person who has a certificate will be protected, to the extent they can get the benefits.

The real question here is reaching the person who sold it, where they are located.

Mr. WYDEN. I appreciate your bringing up that point, Mr. Corcoran, because I think that illustrates what I want to ask Mr. Pomeroy.

It seems to me that if every State does something along the lines of what New York has done, whether it's that or something similar to it, that's the ballgame. That was what Congress was concerned about, the authority to deal with deceptive out of State practices in a given State.

This was my question to you, Mr. Pomeroy. If the States don't, would the NAIC support Federal legislation? Let me ask it in another way. How long should we give the States to enact legislation on this point?

Mr. POMEROY. Mr. Chairman, you asked a difficult question. I believe that we are very, very new into the new regulatory environment after catastrophic, about the fourth month into the new environment. States are rapidly bringing their regulatory framework up to speed, and I believe this is an area that has been a loophole in their jurisdiction that they are moving to address in a comprehensive fashion, meaning that they are addressing it in a substantial manner and all States are moving to address it.

In the event States would fall short, looking back 3 or 4 years from now, I would have a hard time defending State regulation in the event. I fully expect that it will be addressed comprehensively at the State level.

Mr. CORCORAN. Congressman, I insert that I believe most Commissioners would do it in their State and if they have difficulty it would go to their fellow commissioner in their State and say this entity is doing business in my State, license or no license, and request your assistance.

That would be the immediate, practical, de facto, thing to do. As far as how long and how broad these abuses are, I don't really know if they are that substantial. That would be the practical, immediate thing we could do as fellow commissioners, is to simply call up and tell Earl that one of his abusive domestics are picking on my New Yorker's and I need his help.

Mr. WYDEN. I think that your point really illustrates another concern that I have had. That is, what really can the NAIC do—and say another State like Mr. Corcoran's that has moved to try to fill what you have called a loophole, Mr. Pomeroy—what can the NAIC do to bring those States along ultimately that just don't want to move forward?

I mean, you said 3 or 4 years down the road someone at the Federal level could talk about a bill. I am not interested in introducing a piece of Federal legislation on this point. I am interested in deal-

ing with it as quickly as possible, as expeditiously as we can, which clearly is through the established system that we have for insurance regulation which is the State level.

But what can you do to lean on or prod or catalyze those States that are lagers in something like this?

Mr. POMEROY. Mr. Chairman, first of all, let me put in perspective that sometimes the NAIC gets a rap because the model laws are not uniformly adopted. A number of model laws are not intended for uniform adoption. The model laws relating to consumer protection in the senior citizen area are intended for comprehensive adoption unless the States would go greater than the protections put forward in the model, both in the Med Sup area where we are operating with a great deal of interest and public attention and regulatory attention.

We are seeing States move fast and the NAIC is attempting to support States in their legislative drafting and bill introduction, and rule promulgation processes to get these in place. Similarly with long term care insurance, where we have seen more than half of the States having in place some variation of the NAIC model, even though the original NAIC model is about 2 years old.

We have seen, in my opinion, fairly comprehensive and rapid movement by the States, given that some States including North Dakota, have the legislature in session every other year. It takes a while if the department misses a legislative cycle for bill introduction, it will be roughly 2½ years at the earliest that statutory changes can be brought on line.

That is why sometimes there are simple legislative or administrative impediments to moving these things along within a matter of 1 or 2 weeks, or even a few months.

Mr. WYDEN. One last question for you, Dr. Firman. How important, in your view, is individual counseling particularly for seniors with modest incomes and great health needs?

Mr. FIRMAN. I think it is absolutely essential. I think we have seen the limits of the current regulation, we have seen the limits of the current approach which is putting out guidebooks, and the fact of the matter is that despite the regulation and despite the guidebook, the problems persist.

What people really want to know is, they need individual assistance. I don't think there is any substitute for that. I think it would be a more effective use of money rather than hiring 810 more regulators in the State of New York, to get 810 counselors out there who could provide information that would make the marketplace work.

We have to have informed consumers if we are going to rely on a marketplace. Right now, all the evidence suggests that we don't have informed consumers.

Mr. WYDEN. Are there any other comments that our panel would like to——

Mr. POMEROY. Mr. Chairman, I would like to just clarify my preceding my answer. Relative to Medicare supplement, the States will have put the new standards in effect and have those certified by the health care financing administration, or there will be Federal imposition of those standards. In that instance, we are talking

about a 50-State compliance that we believe will be in effect by this fall.

I also want to say that by way of recognition for the consumer advocates on this panel and the advocates on the preceding panel as well as the law enforcement representatives on the preceding panel, that we view their efforts as very much in concert to our concern for consumer protection. We find their expertise, effort and commitment to be of great assistance to us, and we certainly appreciate their concerns.

Mr. WYDEN. Mr. Pomeroy, I appreciate that comment. You and I have talked on a number of occasions over the years on a wide variety of issues, and we appreciate in particular your being here and offering us this information as we try to wrestle with the next stages of this debate and what is clearly a rapidly changing market.

If you or any of our panel members do not have anything additional, we would like to thank all of you. Mr. Hildreth, thank you for your presentation. Mr. Corcoran, I think that your presentation is very important from a large State, and the way you have tackled some of these issues such as the one that we mentioned toward the end about the out of State deceptive practices. Dr. Firman, your work on consumer rights is very helpful as well.

If you all don't have anything to add further, the Chair has a couple of formalities that we have to take care of but we will excuse all of you. Thank you for your help and we will be calling on you probably often in the days ahead as we deal with this issue.

The Chair would ask unanimous consent at this point to told the record open on a number of counts. The Health Insurance Association of America has asked that the record be held open for their statement to be added into the record.

Without objection, that will be so ordered, and the record will be held open for the statement of HIAA.

The Chair would also ask unanimous consent that a statement by Agent Randy Freudig be included in the record. Without objection, that will be so ordered.

The Chair would also ask unanimous consent that questions of the minority be posed to the witnesses. I think this is very appropriate. The minority will have additional questions for a number of our witnesses. Without objection, the unanimous consent request to the minority will be recognized.

Recognizing that we have no additional panel members, the subcommittee adjourned.

[Whereupon, at 1:50 p.m., the subcommittee adjourned.]

[The following material was submitted for the record:]

STATEMENT OF RANDY A. FREUDIG, RHU

Mr. Chairman and members of the Committee, I am Randy A. Freudig, an independent insurance agent from Warrington, Pennsylvania. A function of my agency is directed to the Sales and Service of Health Insurance, both Group and Non Group as well as the distribution of various Health Insurance policies to other Independent Agents located throughout Pennsylvania.

My personal concentration is devoted to the special emphasis that I place upon a Consumer Educational Service which I provide to the General Public titled, "Randy A. Freudig's Senior Health Protection Seminars", which focuses on Catastrophic Health Care made up of Medicare, Medigap, and Long Term Care.

I have delivered over 100 presentations of this Seminar to more than 5000 persons who are members of AARP Chapters, Children of Aging Parents Groups, Chambers of Commerce, Senior Centers, and numerous other varied organizations.

Because I encourage questions at any time throughout the program, the attendees frequently engege in spirited conversation raising questions they have not previously had an opportunity to ask about their personal concerns regarding Medicare, Medigap, and Long Term Care. The success of this Educational Seminar can be measured by a sampling of the attached Seminar ballot which summarizes the position of the attendees as to the direction America should take with regard to health insurance.

In line with this oversight hearing, a special highlight of the Seminar focuses on a discussion of specific Medigap coverages. A slide with large multicolored print emphasizes the sentence:

"ONE MEDIGAP PLAN IS ALL YOU NEED
TO FILL THE GAPS IN MEDICARE".

I am finding fewer and fewer persons who are insured by more than one Medigap policy but, of those who do have more than one plan they can usually be identified as having purchased an additional policy for one of two reasons.

REASON ONE: A Retired person whose Employer provided Group Health Insurance coverage was converted to a Non-Group, Medigap plan. The same Retiree then chooses to purchase a duplicate Medigap plan through membership in an AARP Association or other similar Group membership insured plan because the Retiree did not understand that the converted group plan provided Medigap coverage in an amount usually sufficient to fill the gaps in Medicare.

Retirees sometimes think that an additional Medigap plan will help take the place of their former group Major Medical plan. The purchase of a duplicate Medigap Plan is then made because of the Advertising and Sales Promotional material received through the mail which is perceived by the Retiree to be an answer to provide for this lost coverage.

REASON TWO: Seniors, responding to electronic or print media advertising or through the specialized direct solicitation of insurance agents will purchase duplicate Medigap policies for fear of not having enough insurance. When asked why, they purchased more than one Medigap plan the answer frequently is "to make sure that they have enough insurance protection." They sometimes claim that they intended to change from one policy to another, because an Agent from another company told them to do so. This has left them confused and so they hold onto the duplicate policies.

To eliminate both reasons for duplicate Medigap policies involves four steps.

THE FIRST STEP:

Establish an ongoing Continuing Educational program similar to the Seminar system. Through the Seminars I have learned that printed material including my book titled "Medicare, Medigap, Catastrophic Care and You" does not provide enough information because people want a face to face opportunity to learn, through having their personal questions answered. The Seminar provides a "General Public Forum" while the Agent provides an "Individualized Personal Forum."

Agents have a much more important function than simply making a sale. An Agents most important product is service---. An Agent is responsible to help assess the most appropriate insurance package for the unique needs of the individual. The Agent is responsible for assisting the individual to understand the coverages when an illness occurs, as well as assisting with the processing of the claim. Finally, it is the responsibility of the Agent to act as an intermediary and counselor when there is a misunderstanding between the insured and the insurance Company.

THE SECOND STEP:

It should be a requirement that every Agent must have an Errors and Ommission Insurance Policy. The primary purpose of this requirement would be to eliminate that small group of Agents who may not typically qualify for this coverage because of their questionable insurance practices.

THE THIRD STEP:

It should be required that Agents in all states obtain a yearly minimum of 12 hours of Continuing Educational credits. Otherwise, the State Insurance departments would not renew their licenses.

THE FOURTH STEP:

It should be required that an Agent, as well as the insured sign a statement that is a part of the actual Application for insurance (not a supplement to the Application) that clearly identifies that one policy will not be replacing another without "cause". "Cause" is defined as there being no clear premium or benefit advantage to the insured.

"Cause", would not include the "personal wish" of an insured individual who for personal reasons wishes to change Plans, Company or Agent, but who would along with the Agent still be required to state and sign the reason for the change, in order to protect both the Agent and the Insured by clarifying the reason for the change.

A violation of either "cause", or "personal wish", would be subject to the penalties enacted by the National Association of Insurance Commissioners Model Act, in conjunction with the Unfair Competition and Trade Practices Act.

In conclusion, Agents who, like myself, that are members of organizations such as the National Association of Health Underwriters are proud of the work and services which we perform for the members of our communities.

We're willing to put forth those efforts that demonstrate to our insureds that we have prepared ourselves and that we are willing to provide for the best interest of those whom we serve as though it would be for ourselves.

Thank you for this opportunity to testify.

LINDA JENCKES, VICE PRESIDENT
HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. Dingell, the Health Insurance Association of America appreciates this opportunity to comment on the subject of these hearings. The HIAA is the principal trade association for 330 commercial health insurance companies. Collectively we provide health insurance to 90 million Americans either through the workplace or with individual health insurance polices. Many of our member companies issue policies designed to wrap around or supplement Medicare benefits for senior citizens.

This statement is offered in order to demonstrate once again that the commercial insurance industry is ready to work with all interested parties who share our desire to provide Americans of all ages with efficient and affordable financial security from the effects of accidents, illness and disease with honorable sales practices.

Mr. Chairman, in health care financing as in so many other areas of economic activity in the United States, our nation has adopted an approach to problem solving which puts the government in partnership with the private sector and avoids wherever possible a government which competes directly with private enterprise. The fact is, ours is a pluralistic system of health care delivery and financing, the principal virtue of which is that American citizens are offered diversity in an open market for products to meet their needs.

The HIAA is committed to working with senior citizens, the state insurance regulators and with the Congress, on ways to perfect our pluralistic system of health care financing and to protect our most vulnerable citizens from fraud, abuse or intimidation wherever it occurs. While we believe the problems are isolated, they do need to be stopped or controlled.

The HIAA is proud of its record of helping Medicare beneficiaries insure for the financial liabilities left uncovered by Medicare. Some twenty-two million seniors, or seventy percent of the Medicare eligible population, have private policies designed to supplement Medicare. Our surveys tell us that even more seniors would purchase a policy if they could afford to do so. Effective cost containment which could hold down the 16 percent annual increases in Medicare Part B costs would help make Medicare supplement policies affordable for an even greater part of the senior population. That's something we would welcome. Perhaps your committee could take a look at this problem. A few weeks ago, we presented testimony before the Commerce Subcommittee on the reasons why supplemental policy premiums were rising, despite the introduction of Medicare catastrophic. We will gladly provide you with that information if you wish.

As Medicare has changed, so too have our products. As the Medicare catastrophic coverage is phased in, supplemental policies are being revised to eliminate duplication with the new benefits. This also creates an opportunity for us to offer more coverage for

other services not fully reimbursed by Medicare such as balanced billing by physicians (physician charges in excess of those approved by Medicare), long-term nursing home care and prescription drugs.

The professional staff of this committee helped draft the provisions in the catastrophic bill which are working to assure an orderly transition for Medicare supplemental policies. To my knowledge, insurers and state regulators are taking the steps necessary to comply with the required changes and this process is working smoothly.

While the HIAA tried to convince the Congress that long-term care needs of elderly should be a higher priority for Congress than expanded Medicare coverage for hospital and doctors services, the industry has adjusted to the will of Congress, and is amending its benefits accordingly. We do hope, however, that you see the wisdom of directing whatever future federal health resources may become available for the elderly, into tax incentives that will accelerate a developing market for private long-term care insurance. Based on a recent survey, we have found that most people are willing to pay for their own long-term care policies (which a favorable tax incentive would offer) and feel government's role should be limited to providing care for the poor and near-poor.

In today's hearings you have cited isolated examples of abuse in the marketing of insurance to the elderly. This hearing has also served to highlight the fact that there are laws and procedures in place to find, prosecute, and eradicate the improper and illegal activities of those who would prey upon the vulnerable. Since one of the primary functions of the state insurance departments is to protect the consumer from marketing abuse, we think it appropriate that the examples raised here be dealt with at that level. Let me assure you, Mr. Chairman, that the HIAA will continue to press for changes in state insurance regulations that will help weed out "bad apples" and promote increased consumer protection.

In our opinion, there is no need to add more statutes to the law books. In addition to its broad authority to regulate insurance, virtually every state has in effect the Unfair Method of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance statute. All 50 states have enacted legislation that is equal to the NAIC Medicare Supplement Minimum Standards Model Act. While the text of the Unfair Trade Practices Act is lengthy, it addresses virtually every aspect of company and agent activity and prohibits practices such as providing false information or advertising, rebates, unfair discrimination, unfair claim settlement practices and other unfair methods of competition or deceptive acts or practices. Insurance departments have other sanction authority such as the agent licensing laws which also enable the state to issue fines, revoke licenses and publicize the

results of disciplinary actions. While we have enough laws, how to improve their enforcement remains a valid question.

For the benefit of this hearing record, I would like to explain a few commonly misunderstood areas affecting Medicare supplemental policies. Specifically, I would like to discuss the role that professional health insurance agents play in selling and serving Medicare supplemental policies, and the use of Medicare supplemental policy loss ratios as a measure of the policy's value to consumers.

UNDERSTANDING THE ROLE OF AGENTS

Mr. Chairman, it is unfortunate that these hearing did not include testimony from any of the hundreds of thousands of highly professional individual health and life insurance agents. With their help, along with other consumer representatives, we feel certain we can come up with constructive ideas for further reducing even the occasional instance of abusive marketing to the elderly.

Because licensed agents help bring health insurance to millions of individuals young and old, their important role should not be misunderstood or underestimated. Agents can perform all of the following services for the elderly: explain Medicare's benefits; describe how policies will pay benefits, hand deliver

policies and review options; answer questions; assist in claims filings, and help schedule medical PRO reviews.

If a senior citizen has retiree health insurance carried over from his/her former place of employment as some 35 percent of Medicare beneficiaries do, they might not see an agent. Seniors who are members of a group or association which offers access to a group Medicare supplement policy, as some 40 percent of beneficiaries are, probably buy through the mail. However, about 25 percent of beneficiaries chose to purchase individual Medicare supplemental policies through a professional health insurance agent in the neighborhood.

The fact that approximately 8 million seniors turn to agents for advice on their health insurance needs is testimony to the value of the service they offer. Understanding the Medicare program and its benefits can be difficult and confusing. Beneficiaries in need of advice can call the regional Social Security office, the local Medicare carrier or intermediary and the area senior's consumer hotline. Or, they can rely on their local licensed professional health insurance agent, or call one from the yellow pages. In the vast majority of cases, the elderly turn to the agent who has the training, time and answers to best help them.

The main reason why the cumulative loss ratios for agent delivered policies do not match group policies and mail order

policies is the additional cost for the level of service provided by agents. Service is definitely a benefit desired by millions of policy holders. It is a cost not recognized for purposes of calculating loss ratios.

In recognition of the importance of the service that agents provide, the federal and state minimum standards for individually sold Medicare supplement policies require a 60 (65 percent in some states) loss ratio rather than the 75 percent loss ratio for group policies including the AARP's products.

While direct mail and associations can be used to sell basic policies which meet the federal minimum standards, companies have found that many people want a trained agent to explain Medicare benefits and the need for supplemental coverages, including long-term care.

LOSS RATIOS MUST BE EXAMINED

The GAO recently submitted a report to this Committee on 1987 loss ratios. While the report represents only a one year snapshot in time, it does show the overall difference between group and agent-delivered products.

Group policies, primarily Blue Cross/Blue Shield and AARP/ Prudential, have marketing and distribution systems that are unique to their organizations, but neither rely on professional

health insurance agents. By comparison, there is no question the agent delivery system costs more, however, it also reaches individuals who are not covered by group plans.

Loss ratio requirements of the Baucus Amendment and the NAIC Model Standard for Medicare Supplement Policies state that agent-delivered policies should return to their policyholders 60 percent of the total premiums over the entire premium paying period. In other words, the loss ratio is to be calculated over the entire period for which the policy is in-force, not each year.

Here are the reasons this standard should not be used to measure a single year's performance:

- In pricing Medicare supplement policies, premium income is designed to be a level fixed cost. While this figure will fluctuate with time, premium increases for in-force policies must be kept relatively stable over the life of the policy to ensure policyholder satisfaction.

- Claims incurred on a policy are low in the early years and grow with time. This is because health underwriting of new applicants produces an initially healthier than average insured population. Over time, this group's claims experience becomes more like the average, and then evolves to higher than average as policyholders' age and utilization of health care services increase.

The fact that individuals who drop their policies tend to be healthier on average than those who hold onto their policies, also adds to increasing claims costs over time.

The result is lower claim loss ratios in the early years of a policy and higher loss ratios in later years.

To illustrate how a policy's loss ratio develops over time, we have selected a policy from the GAO's report to the Committee on 1987 loss ratios. It documents the premium income and claims experience from a typical Medicare supplemental policy sold to individuals by professional, state-licensed health insurance agents. It happens to be one of the best selling policies in the U.S. It was also selected as the best value for seniors in 1984 by Consumers Reports magazine.

As reported in the current GAO study on 1987 experience, this policy paid $83,034,652 in incurred claims on earned premiums of $136,477,324 for a loss ratio of 60.8 percent in 1987. Viewed by year of issue, however, the loss ratio ranged from 45.0 percent to 66.3 percent:

UA Policy Form: MAXC
Calendar 1987 Experience

	Earned Premiums	Incurred Claims	Loss Ratio	
1983 issues	$ 20,440,090	$ 13,192,231	64.5%	5 years from issue
1984 issues	46,094,728	29,794,405	64.6%	4 years from issue
1985 issues	46,856,188	26,267,830	56.1%	3 years from issue
1986 issues	15,918,415	10,554,581	66.3%	2 years from issue
1987 issues	7,167,903	3,225,605	45.0%	1 year from issue
TOTAL ALL YEARS	$136,477,324	$ 83,034,652	60.8%	CUMULATIVE ALL YEARS

The GAO did not have 1988 experience when their report was issued. The company does, however, and we provide it here to show what the GAO would see if they did a report of 1988 loss ratios. For the same policy, the loss ratio would be 66.7 percent versus the 60.8 percent reported for 1987; this time loss ratios viewed by issue year would range from 41.4 percent to 72.9 percent:

UA Policy Form: MAXC
Calendar 1988 Experience

	Earned Premiums	Incurred Claims	Loss Ratio	
1983 issues	$ 15,444,402	$ 10,873,656	70.4%	6 years from issue
1984 issues	33,915,037	24,011,474	70.8%	5 years from issue
1985 issues	33,756,315	21,019,077	62.3%	4 years from issue
1986 issues	10,386,732	6,793,290	65.4%	3 years from issue
1987 issues	11,404,652	8,313,391	72.9%	2 years from issue
1988 issues	4,153,775	1,719,305	41.4%	1 year from issue
TOTAL ALL YEARS	$109,060,913	$ 72,730,193	66.7%	CUMULATIVE ALL YEARS

Now let's go back to the last time the GAO reported to Congress on Medicare supplemental loss ratios. The year was 1986 and the report was based on 1982-1984 experience. Again, this product was introduced in 1983 and rated the best value product available nationwide by Consumers Reports in 1984. Here's what the last GAO report would have reflected on this policy:

UA Policy Form: MAXC
Calendar 1984 Experience

	Earned Premiums	Incurred Claims	Loss Ratio	
1983 issues	$ 46,212,780	$ 25,834,687	45.3%	2 years from issue
1984 issues	53,464,053	10,783,282	20.2%	1 year from issue
TOTAL ALL YEARS	$ 99,676,833	$ 36,617,969	36.7%	CUMULATIVE ALL YEARS

The point is that proper-priced products must have low loss ratios in the early years and higher loss ratios in later years to avoid wild fluctuations in rates and/or company insolvencies. And that is why state regulators must examine loss ratios by policy, by issue year and over time. It is not as simple as looking at one point in time and drawing a conclusion. Yet this is consistently the approach taken by consumer groups and the press fueled by reports like the current GAO's on one year's experience.

One last point should be noted. The proper development of loss ratios over time is critical on guaranteed renewable products where the company can never cancel a policy for any reason, including advancing age and declining health, as long as premiums are paid. Unlike group policies, virtually all agent-delivered Medicare supplements are guaranteed renewable.

CONCLUSION

In conclusion, Mr. Chairman, the highly competitive Medicare supplemental market is responding well to the needs of Medicare beneficiaries. It provides twenty-two million senior citizens with options in benefits, premiums, and levels of personalized service. While you have chosen in these hearings to focus on isolated cases of marketing abuse and have demonstrated the inherent difficulty in eradicating such practices, I am confident that all those seniors who purchase or maintain Medicare supplemental policies year after year find good value in these products and in the service provided by the professional health insurance agents who advise them.

To: Subcommittee on Oversight and Investigation
From: James Firman, United Seniors Health Cooperative
Subject: Response to Additional Questions
Date: May 19, 1989

Question #1: In your testimony, you state that your organization operates an Insurance Help Line which enables you to track problems with Medigap policies. Do you systematically analyze and tabulate these complaints received on your helpline?

Response: As reported in my testimony of April 26, 1989, USHC currently operates a Health Insurance Help Line as a free service for our 10,000 local older members. The service is provided both by paid professional staff and volunteers trained by our organization. A "Call Sheet" is kept for each caller who has a question that requires more assistance than just a quick answer or additional information that cannot be provided easily. The Call Sheets contain a client's name, phone number and notes about the follow-up that is required. If Committee staff would like to review these Call Sheets, we would be glad to provide appropriate access, provided that client confidentiality can be assured.

It is important to note we operate an information service, not a "complaint hot-line". Most of the older persons who call have questions, not complaints. They are confused about their coverage or uncertain about what they should do about their supplemental insurance. They are seeking information or assistance to enable them to make decisions.

Question # 2: Do you systematically survey your membership to determine their experience with Medigap policies? If no, in making generalizations about sales practices and duplicative coverage, shouldn't you base these conclusions on systematic studies rather than phoned-in complaints?

Response: United Seniors has not conducted a mail survey of its members to learn their experiences with Medigap insurance. Population-based surveys have been conducted by the Health Insurance Association of America (HIAA), AARP and other organizations. My testimony was based primarily on the experiences of people who call our Help Line and from discussions with our highly experienced professional staff who are involved in counseling older persons on a daily basis.

A not-for-profit organization of health care consumers

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It is important to note that our experiences with the Help Line are entirely consistent with the findings reported by the HIAA. The HIAA's own study reported that approximately 25% of the older persons surveyed in March 1987 had more than one supplemental insurance policy. Virtually every older with more than one supplemental policy has at least some duplicative and wasted coverage. The HIAA data suggests that, on a national basis, as many as 5,000,000 to 6,000,000 older Americans have duplicative and wasted coverage.

Question #3: In your testimony, you say the Baucus amendment is inadequate to control abuses. However, the systematic studies conducted by Federal agencies conclude that the Baucus amendment in combination with State efforts is protecting the elderly against substandard Medigap policies. Do you wish to comment?

Response: Yes. In a report to the Committee, the General Accounting Office found that that 48 of 98 policies studied had 1987 loss ratios below 60% which is the minimum standard set by the Baucus amendment and the NAIC model regulations. In other words, 49% of the policies studied were "substandard" by this commonly accepted definition. This is pretty clear evidence that elderly consumers are not being protected against substandard policies.

The Baucus amendment has also failed to stop the sale of a considerable amount of duplicative and wasted coverage to older persons. I doubt that either an industry spokesperson or reputable insurance expert can be found who would assert that it makes sense for a Medicare beneficiary to have more than one supplemental policy. However, the HIAA data, which is consistent with our own experiences, is clear evidence that millions of older persons currently have more than one policy.

Question #4: FTC studies show that most policyholders are satisfied with their company's claims performance. Would you like to comment on these findings?

Response: FTC findings about claims performance are consistent with our own experiences: most people who file a covered claim can eventually expect to be paid. Satisfactory claims experience is separate from and does not contradict GAO findings about substandard policies and HIAA findings about duplicative coverage.